HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH

AND SOCIAL SECURITY

VOLUME 20, NO. 11, ABSTRACTS 1501-1654. NOVEMBER 1980

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HOSPITAL ABSTRACTS

Vol. 20 November, 1980 No. 11

HOSPITALS IN GREAT BRITAIN

1501. Planificación hospitalaria en Gran Bretaña. **[Hospital planning in Great Britain.]** *Estudios sobre Hospitales*, Barcelona, 1980, March/June, no. 101/102, pp. 16-21.

In November 1979, the British Council held an exhibition in Barcelona on the subject of hospital planning in the United Kingdom. A series of 24 large panels combining photographs with a short explanatory text was used to illustrate the sequences in the planning system—brief, design, production, construction, commissioning and evaluation. There is considerable interest in Spain in many aspects of the National Health Service and in the work of organizations such as the King Edward's Hospital Fund, the Nuffield Hospital Trust and the Acton Society. Two of the King Edward's Hospital Fund's publications, 'Commissioning a new hospital' and 'Living in the hospital' have been translated into Spanish.

HOSPITALS IN OTHER COUNTRIES

1502. ARCTANDER, P. Sygehusbyggeri år 2000. **[Hospital building in the year 2000.]** *Tidsskrift for Danske Sygehuse*, København, 1979, Oct./Nov., vol. 55, no. 9/10, pp. 205, 206.

The author looks forward to the year 2000 and the possible developments in health care in order to assess their effects on hospital building. While accepting that current trends are likely to continue, he questions the view that 'bigger' necessarily means 'better' and examines the aims of hospital building. He believes one should not fall into the trap of opting completely for small local health centres, but that we should have diversity in our health care provision. Certain forms of treatment require the technical resources of a large hospital, while in other cases it is of more value to be nursed near to one's home. In the author's view there is now a great danger of hospitals becoming isolated from the community, and he suggests that decision-making powers should be handed over more to those who are served by hospitals, i.e. representatives of users. He concludes by stating that the Danish hospitals of the year 2000 will depend on an analysis of likely requirements, leading to wise decisions.

1503. DANISH HOSPITAL INSTITUTE. **Review of activities 1978-1979.** Copenhagen, Danish Hospital Institute, 1980. 68pp. ISBN 87 7488 0756 D.Kr. 20.00.

The Danish Hospital Institute is an independent research organization set up to analyse and disseminate information in the hospital and health services field and to carry out developmental research into aspects of planning, rationalization and management. In this review, research projects undertaken by the Institute are described and details of resulting publications are given. Reports, conferences and courses for the

period are listed, as are articles and lectures by staff members. The review also contains information on the membership, organization and bye-laws of the Institute.

1504. Stuurgroep regionale planning rapporteert. **[Report of the steering committee on regional planning.]** *Ziekenhuis*, Utrecht, 1980, July 16, vol. 10, no. 13/14, pp. 396-399.

The Government aims to promote a system of co-ordinated health care services within the regions. This is stimulated by recent legislation dealing with the intramural services of hospitals, other sectors of health care, staffing, hygiene, safety and efficient functioning. The object is a complementary structure of administration between national and regional authorities, with the national authorities setting the norms within which the regional authorities can plan their health services in co-operation with their hospitals, nursing homes and municipal authorities. The National Hospital Council has the work of promoting a system of intramural co-operation between member hospitals including the extramural activities of psychiatric institutions. Individual hospitals and other health institutions can contribute to the planning by joint discussions on initiation and preparation of proposals, co-ordination of these proposals between the different sectors and decisions on their administration. This would require further regulations to deal with reports on the initiatives, information, decisions and execution.

PLANNING, DESIGN AND CONSTRUCTION

DETERMINING SIZE OF HOSPITAL AND BED NEEDS

See Abstract No. 1646

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

1505. Hitt, Peter. **Horizontal design retained in expansion.** *Hospitals*, Chicago, Ill., 1980, July 16, vol. 54, no. 14, pp. 73-74, 76.

In the scheme for expansion and modernization at Tucson Medical Center, Arizona, architects and administrators agreed that the development of the existing single floor building was the most suitable approach for the hospital's desert setting and mode of operation. The expansion of facilities was achieved by clustering diagnostic and treatment services in a compact central core and grouping the bed wings on one side. Three key internal routes were identified to improve circulation: one from the main entrance, one from the out-patient entrance and one from the bed wing entrance. The corridors were widened and a colour-coded sign system was developed to direct movement along the main routes. Bed units of 36 beds are paired to share certain treatment and core facilities. External polystyrene panels provide good insulation and demountable internal wall panels allow for flexibility. Windows are aligned to provide a view for patients and keep heat out and a skyway throughout the hospital consolidates the electrical and mechanical distribution systems for easier maintenance.

EXTENSIONS AND RECONSTRUCTIONS

1506. United States. National Center for Health Services Research. **Health facility reuse, retrofit and reconfiguration: [conference held] April 24-26, 1978, Columbia University, New York.** Hyattsville, Md., National Center for Health Services Research, 1980. ix, 102pp. bibliog. (DHEW Publication No. (PHS) 79-3257)

Interest in health building re-use and conversion in the United States has been quickened by rising health service costs and a surplus of acute care hospital facilities. This conference, involving architects and health service administrators and planners, was held to allow an exchange of experiences and to develop an organized research agenda for future work in health building re-use. It was concerned with six critical issues: (i) financial feasibility; (ii) codes and standards; (iii) systems approaches; (iv) project implementation; (v) planning strategies; and (vi) facility evaluation. For each of the issues, the conference took the form of a position paper presented by a subject expert, together with a formal reaction by one or more individuals, followed by a summary and recommendations prepared by a panel of conference participants.

1507. Nybygg ved Buskerud Sentralsykehus. **[Reconstruction of Buskerud Central Hospital.]** *Norsk Sykehustidende*, Oslo, 1980, vol. 53, no. 6, pp. 12-14.

The new hospital for the Buskerud region replaces the old Drammen Town Hospital which opened in 1887 with a total of 40 beds. The 15-floor central block of the new hospital stands out as a landmark in the centre of Drammen. Planning of the new hospital, which was to have 830 beds, began as long ago as 1968. In fact, there are only 700 beds. In addition to the tower block which contains the patients' rooms and the gynaecology, paediatrics, medicine, surgery, neurology, ENT, and ophthalmology departments, there is a central supplies building which contains the kitchens, laundry and central stores. A further building houses the heating complex, the waste disposal and incinerator department, and the emergency generator. Further developments in the pipeline include the modernization of the out-patient gynaecology and medical clinics, the enlargement of the therapy section, rebuilding of the laboratories and X-ray department, and the construction of a new administrative block. The architects for the project are Ragnar Anker Nilsen and Arne Grenager of Drammen. This description includes a photograph of the exterior of the hospital, three photographs of the interior, and a site map.

DESIGN OF SPECIAL DEPARTMENTS

1508. Department of Health and Social Security and Laboratories Investigation Unit. Joint Working Party on Laboratory Design. **Interim report: January 1979.** [London, DHSS, 1979]. 11pp.

In 1975 a joint working party of the Department of Health and Social Security and the Laboratories Investigation Unit (LIU) was set up to assess the suitability and financial feasibility of the LIU's design concept for use in health service laboratories. The working party visited hospital pathology laboratories and buildings incorporating the LIU designs, and cost data relating to LIU designs were made available to assess applicability in the health service. A high degree of adaptability

was seen as an essential requirement of pathology laboratory design. The working party agreed that the LIU equipment and services installations previously developed would need selective development for application in the health service, and that this could only be effected through a 'design and build' pilot project. The brief for the project should take into account: (i) DHSS Building Note 15; (ii) the Howie report; (iii) specification notes prepared by user members of the working party; (iv) proposed revisions to British Standard 3202 on safety cabinet and fume cupboard design and location; and (v) an expenditure limit based on normal DHSS cost targets related to the stated user requirements.

DESIGN OF SPECIAL HOSPITALS OR UNITS

See also Abstract No. 1625

1509. STEPINSKI, Zygmunt M. and BOLECHOWSKI, Jacek. **The Child Health Center.** *Architektura*, Warsaw, 1979, Nov./Dec., vol. 33, no. 11/12, pp. 62-73.

This paper presents, in Polish and English, general data on the Child Health Center, Warsaw, and an interview with the architect, whose design was chosen as the winner of a competition for which there were 39 entries. The hospital, which has been built as a memorial to children killed in the Second World War, has 498 beds. The main complex (the first and second stages) consists of nine interconnected buildings. The third stage will provide a rehabilitation centre of five buildings connected to the main complex. Plans and photographs are included.

OTHER ASPECTS: EVALUATION OF BUILDINGS

1510. DRUMMOND, Pauline. **Throwing bricks at design.** *Health and Social Service Journal*, Basingstoke, 1980, Sept. 26, vol. 90, no. 4712, pp. 1256-1259.

This paper presents a survey of structural defects which have been reported in British hospitals in recent years and examines some of the reasons for them. Particular problems have occurred with flat roofs and new floor screeds introduced to cut costs. Minor repairs can be remedied quickly, but are often left until they become major capital works and become the responsibility of the regional authority. Other problems include: structural difficulties in high-rise blocks; design problems resulting from long delays in completing projects; decline in numbers of skilled craftsmen; lack of experience with new materials; and loss of control over the work force by large contractors. There are signs that recent trends in hospital design and construction methods should overcome these problems.

ENGINEERING SERVICES

HEATING

1511. SMITH, A. **An explosive problem.** *Health and Social Service Journal*, Basingstoke, 1980, Sept. 26, vol. 90, no. 4712, pp. 1260-1261.

Portable liquid petroleum gas heaters, which have a very high heat output, are

increasingly being used in hospitals to provide supplementary or emergency heating. Unfortunately these heaters present a greatly increased fire risk and users should consider very carefully whether the risk is acceptable before putting such heaters into hospital accommodation. In a genuine emergency the heaters may be used in hospitals provided certain precautions are observed to minimize the hazards inherent in their use. These precautions are listed. It should always be confirmed that these precautions are practicable. The heaters must be properly installed and maintained by trained works staff with the gas correctly piped into the building from cylinders situated outside in the open air.

VENTILATION AND AIR-CONDITIONING

See Abstract No. 1583

MAINTENANCE OF BUILDINGS AND EQUIPMENT

See also Abstract No. 1517

1512. VRIES, Jan de. **Hospital maintenance: consequences of costs and safety aspects.** *Hospital Engineering*, London, 1980, Sept., vol. 34, no. 7, pp. 8-10.

The economic situation and ever-increasing costs call for very careful consideration of expenditure. To obtain the maximum advantage from expenditure on maintenance, the available money should be spent in such a way that buildings, installations and equipment used by medical and nursing staff are kept in good condition. Preventive maintenance also stands for a planned system of safety measures. This paper is particularly concerned with the need for additional safety checks on diagnostic and therapeutic instruments. These are necessary to ensure the instruments are giving the correct information, particularly in departments of nuclear medicine. Because of the increasing complexity of technical and physical aids, it is questionable whether medical and nursing staff can be held responsible for their proper functioning; engineers and biomedical technicians must be willing and able to accept part of that responsibility. An investigation in the Netherlands has recommended a clearer division of maintenance into categories. It has also suggested a process for developing a preventive maintenance system. It is desirable that hospital engineers should receive special training to enable them to provide: a good working system of preventive maintenance; correct safety precautions, especially as regards electrical safety; and technical measures to prevent hospital infection.

SANITARY EQUIPMENT AND FITTINGS

1513. DANSK SYGEHUS INSTITUT. Vandforsyning, vandbehandling og vandkvalitet på danske sygehuse: sygehusenes vandforsyningssystemer samt undersøgelse af tempereret vand. **[Water supply, water treatment and water quality in Danish hospitals: the water supply of hospitals including an examination of temperate water installations.]** Copenhagen, Dansk Sygehus Institut, 1980. 72pp. (Projektrapport 80.03) ISBN 87 7488 1418 Kr.40.00

An examination was performed of the water supply, water treatment and water

quality in Danish hospitals. The examination took place in two stages: (i) questionnaires were completed by 123 hospitals, which showed that only a limited control of water quality was performed, that temperate water systems with reservoirs were found in a number of the hospitals and that reserve water supplies were available in less than half the hospitals; and (ii) water samples were taken from temperate water systems and from cold and hot water systems in 26 of the hospitals, providing evidence that treatment and distribution of water in hospitals may involve a risk to the quality of the water in bacteriological respects. A conference was subsequently held at which two recommendations were emphasized: (i) that supply systems and installations which favour the growth of undesirable micro-organisms should be avoided; and (ii) that quality control should be established in hospitals which can survey and evaluate water quality, and that the control should be followed up. Recommendations arising directly from the water supply examination were that: (i) temperate water systems with a reservoir should not be installed in future; (ii) other technical solutions should be applied if temperate water is required; (iii) the quality of water in existing temperate water installations should be surveyed and appropriate measures taken in the case of unsatisfactory results; (iv) quality control should be established in hospitals by experts; and (v) periodical control of cold, hot or temperate water should be established. Twenty references to the literature are listed.

EQUIPMENT, FITTINGS, FURNITURE

WARD FURNITURE, FITTINGS AND EQUIPMENT

1514. LAMMENS, J. Materialenkeuze. **[Choice of materials.]** *Hospitalia*, Brussel, 1980, April/June, vol. 80, no. 2, pp. 99-103.

Materials used in hospital building should be strong, easily maintained, hygienic, financially justified and of aesthetic appeal. Wall partitions should be of simple, flexible material, durable, fire-resistant, sound insulating, quick and convenient to construct. Plaster-board re-inforced with metal wiring produces satisfactory results, though hanging heavy objects require advance planning or plaster screws. Floor covering should be fire-resistant, easy to clean, non-slip, non-tiring to feet, sound absorbing, pressure-resistant and of pleasing colour design. Marble, large tiles, carpeting, linoleum and PVC are discussed. Wall coverings require similar qualities with special damp-resisting materials for some sections. Cloth coverings, PVC on linen, PVC on foam and tiled walls are discussed. Materials for lowered ceilings should similarly comply, with the emphasis on acoustics. Satisfactory results have been obtained using ceiling panels with vertically mounted sound barriers of aluminium micro-perforated lamellae covered with synthetic wool. Wall protection against damage should be provided particularly at corners and the vulnerable area between 45 and 80 cm above the ground. Metal plates and corners, buffer strips, grip handles and automatic door openers are recommended. Beds should be roomy, mobile, highly adjustable, fully proof against steam and alcohol disinfection; bedsteads should be of rustproof steel tubes, preferably built in one piece.

MEDICAL EQUIPMENT

See also Abstract No. 1584

1515. HARGEST, Thomas S. **A clinical engineer's view of medical instrumentation.** *Medical Instrumentation*, Arlington, Va., 1980 July/Aug., vol. 14, no. 4, pp. 215-217.

Physicians and nurses often assume that a better level of patient care exists when modern instrumentation is involved. This is true only when equipment applicable to the problem is carefully selected, properly maintained and used in suitable surroundings by staff who understand how the equipment works. If any of these components is missing, there may be danger for the patient. Hospitals operating sophisticated equipment must have clinical engineering support in the form of competent technical staff to ensure safe operation. Technical staff must know not only how the equipment works, but also why it is used and what it is supposed to do. Selection of equipment should be made only after careful evaluation. All departments and staff involved with the acquisition should be informed of the intent to purchase and the proposed application.

1516. TURNER, Glenn O. **Instrumentation problems for physicians.** *Medical Instrumentation*, Arlington, Va., 1980, July/Aug., vol. 14, no. 4, pp. 207-210.

The modern American doctor has decreased his level of involvement in the development and evaluation of medical technology, particularly instrumentation. The chief problems facing the physician are: (i) the outcry concerning rising hospital costs; (ii) charges of a lack of humanity in the health care system; and (iii) lack of cost data when deciding to purchase a particular instrument. An important factor to remember is that although the cost of modern machines is high, they usually provide major improvements in patient care. The health care team of physicians, nurses, therapists and technicians have their capacities for diagnosis and treatment greatly extended through modern instrumentation. Physicians should present material about instruments at their meetings and share information with administrative staff. The public must be educated in the benefits of modern medical technology in an effort to counter the accusations of inhumanity.

1517. BUCHER, Guy and RAMBAUD, Monique. La maintenance des équipements médicaux à l'Assistance Publique. **[Maintaining medical equipment in the Assistance Publique.]** *Hôpital à Paris*, Paris, 1980, March/April, no. 56, pp. 133-135.

The Assistance Publique has inaugurated a new approach to maintenance policy because one directorate is now responsible for both maintenance and purchases. In the past most AP maintenance contracts combined regular maintenance visits with calls to repair equipment whenever it broke down; charges for both types were established in advance. There are now no fixed maintenance charges; the frequency of preventive maintenance calls is being reviewed; at each visit, a list of jobs done, equipment dealt with, and time spent must be supplied. An estimate must be given for any repair costing more than 1,000 francs, and an AP biomedical engineer must approve the estimate when it amounts to more than 3,000 francs. Suppliers may now

be penalized if there are delays in servicing or if the standard of repair work is poor, and a ceiling has been fixed for the annual increases in maintenance charges.

1518. SCHULTZ, Janet K. **Nursing and technology.** *Medical Instrumentation*, Arlington, Va., 1980 July/Aug., vol. 14, no. 4, pp. 211-214,

Over the past 30 years, the nurse has had to care for machines as well as patients. Nurses have had to acquire new skills to interpret data obtained from modern methods of instrumentation. In the 1970's, the nurse became familiar with monitoring and therapeutic devices, such as ultrasound, cardiac pacemakers and many different types of respiratory therapy equipment. The operating theatre nurse also deals with more technology. There is no area of nursing practice left unaffected by advances in health care technology. Nurses' time has also been taken up by becoming familiar with electronic data processing systems, although these should free her to spend more time with patients. Nursing education has not kept pace with technological developments and their effect on nursing practice. Nursing courses should include a course in biomedical engineering and hospitals should instruct newly qualified nurses in the use of equipment.

1519. BUCHMUELLER, David P. **The management perspective of medical instrumentation.** *Medical Instrumentation*, Arlington, Va., 1980, July/Aug., vol. 14, no. 4, pp. 201-205.

At a time of limited resources, decisions involving the acquisition and use of medical technology should involve the opinions of doctors, nurses and other staff involved in patient care. Each hospital should have a means by which medical staff can review all new patient care procedures before granting approval for these procedures. There should be a capital equipment review committee which should: (i) consider what proportion of funds should be used for capital expenditure; (ii) make recommendations with regard to items to be purchased; and (iii) balance the allocation of resources by setting priorities. Doctors and nurses must provide data on expected use of new equipment so that a cost analysis can be performed by management staff. Using information provided by manufacturers, the hospital administrator must design a plan for introducing the new schedule and carrying out the necessary staff training. Other factors to be considered include: (i) acquisition costs; (ii) operating costs; (iii) possible risks to patients; and (iv) arrangements for maintenance and service.

LABORATORY EQUIPMENT

See Abstract No. 1574

ELECTRONIC EQUIPMENT

1520. WINTERBOTTOM, J. T. **Equipping an ECG department.** *British Journal of Clinical Equipment*, London, 1980, Sept., vol. 5, no. 5, pp. 176, 178-179.

This brief review of the equipment used in electrocardiography departments makes only brief reference to technical specifications and is mainly concerned with the

underlying principles, with emphasis on recent developments. Special considerations discussed are alternative equipment, ease of operation, safety, supplies and housing. Choice of equipment is discussed for: routine electrocardiography (single- and multi-channel machines); ambulatory arrhythmia monitoring; exercise electrocardiography and stress testing; and computer-assisted electrocardiography.

STAFF GENERALLY

RELATIONS BETWEEN ADMINISTRATIVE AND MEDICAL STAFF

1521. HEPNER, James O., editor. **Hospital administrator-physician relationships.** St. Louis, Mo., London, C. V. Mosby, 1980. xxi, 422pp. (Case Studies in Health Administration Vol. 2) ISBN 0 8016 2158 5 £12.00

This book forms part of a series produced by the American College of Hospital Administrators and is made up of 64 case studies of administrative issues in United States and Canadian hospitals, preceded by two introductory chapters. The authors of the case studies, who are hospital administrators, present a problem from their own experience, describe the administrative decision intended to overcome it, record the results and suggest issues for discussion. There are 10 sections: an introduction, offering a theoretical framework of relationships between hospital administrators and physicians; social influences which are outside the control of the hospital, e.g. legislation; physician involvement in hospital management; hospital medical staff organization; management of medical staff by administrators or trustees; discipline of medical staff, where involvement of administrators and trustees is a particularly sensitive issue; physician recruitment; hospital physicians' office buildings; hospital professional service contracts; and emergency medical services, ambulatory care and hospital-based group practice.

SALARIES AND SUPERANNUATION

1522. HOWELL, L. C. **Fairer system for nurses' pay.** *Health and Social Service Journal*, Basingstoke, 1980, Sept. 5, vol. 90, no. 4709, pp. 1171-1173.

Any system to resolve the problem of proper remuneration in the nursing service should: (i) be considered part of the total nursing contribution, that is the clinical, management, educational and research contributions; (ii) be based upon sound judgment and the considered value of these contributions; (iii) afford similar opportunity of professional development for each of the four nursing groups (clinical, management, educational and research); and (iv) prove acceptable to the four nursing groups. This paper outlines a model for such a system which assesses factors relating to qualifications, training, experience and responsibilities of particular relevance to each of the four nursing groups. A number of suggestions for implementing the model are made, including separate pay structures for the four disciplines within nursing.

Salaries would be private as the personal/professional information regarding the factors linked to remuneration would be confidential. The system could be delegated to the local health authorities or alternatively control could be maintained at the centre. The model described would require a great deal of perfecting, but it should prove generally acceptable to the great majority of the nursing profession. It offers a positive incentive for nurses to develop their professional knowledge and performance in whichever branch of nursing they feel most able to make a contribution.

STAFF MANAGEMENT

See also Abstract Nos. 1529, 1602

1523. EATON, Philip and GOTTSELIG, Susan. **Effects of longer hours, shorter week for intensive care nurses.** *Dimensions in Health Service*, Ottawa, Ont., 1980, Aug., vol. 57, no. 8, pp. 25-27.

In response to a request from staff nurses of the intensive care unit at the Holy Cross Hospital, Calgary, a plan to introduce a shorter working week with 12-hour shifts was devised. A study was designed to determine the effects of the 12-hour shift on: (i) job satisfaction; (ii) work environment; (iii) health of the nurses; (iv) fatigue and alertness of the nurses; and (v) the quality of patient care. A group of 24 registered nurses were tested one month before and six months after the introduction of the 12-hour shift system. No significant differences were obtained with regard to job satisfaction, but the 12-hour shift did offer the opportunity to undertake a greater variety of tasks. The new shift did not cause any overall decrease in alertness or increase in fatigue, but nurses on the day shift performed the reaction tests quicker than those on the night shift, a fact generally evident in night work whatever the length of shift. The quality of patient care was not affected adversely by the 12-hour shift; in fact the greater continuity of care was expected to lead to improved care after a longer period of time.

STAFF RELATIONS

1524. SKEVINGTON, Suzanne M. **Intergroup relations and social change within a nursing context.** *British Journal of Social and Clinical Psychology*, Letchworth, 1980, Sept., vol. 19, no. 3, pp. 201-213.

Tajfel's theory of intergroup relations was used to predict the responses of 40 high (state registered) and low (state enrolled) status nurses to the possible effects of social change in the form of a merger of the two groups. Evidence is presented to support the prediction that the high status group are threatened by loss of status, and will emphasize their superiority if change occurs. The high status group is highly evaluated by both groups and, even when social change is rejected, the low status group still continues to evaluate the high status group favourably. Contrary to prediction, low status nurses do not perceive current status relations to be more illegitimate than the high status group; but as a group they show more hostility than the high status group,

especially in situations which demand co-operation rather than competition. The results are interpreted in terms of the theory and the social context of nursing.

STAFF TRAINING

See also Abstract Nos. 1530, 1531, 1532, 1535, 1617

1525. AMSTERDAM, James T. and others. **Interdisciplinary training: hospital dental general practice/emergency medicine.** *Annals of Emergency Medicine*, Irving, Tex., 1980, June, vol. 9, no. 6, pp. 310-313.

Direct educational interaction between dental and medical students, residents and their faculties is encouraged by a unique affiliation between the Medical College of Pennsylvania and the University of Pennsylvania School of Dental Medicine. In particular, there is close interaction in the training of residents in the hospital dental general practice and emergency medicine residency programmes. The two programmes and the training they provide are outlined. The dental resident's experience is increased markedly by his attendance at weekly emergency medicine grand rounds and exposure to emergency conditions in concert with the emergency medicine resident. In the same way, the depth and scope of the emergency medicine resident's knowledge and experience of the head and neck are advanced. As dento-facial emergencies present themselves more frequently in the emergency department, the emergency physician must be trained and prepared to manage such problems, especially when a general dentist or oral surgeon may not be immediately available. This training is achieved through interaction with the dental staff.

STAFF WELFARE

See Abstract No. 1573

OTHER STAFF AMENITIES

1526. BIBBY, D. M. and THOMAS, R. F. M. **Government policy on day nurseries for children of hospital staff.** *Social Policy and Administration*, Oxford, 1980, vol. 14, no. 2, pp. 115-123.

The essential propositions of Department of Health and Social Security guidance on day nurseries are: (i) hospitals should consider establishing nurseries to help recruit and retain staff; (ii) nurseries are likely to be rather costly; and (iii) the nursery should be open to children of all staff employed by a hospital and the age of these children should not normally be less than two years. This paper relates this policy to the situation at a large city hospital in order to ascertain the relevance of the policy. It is based on a survey of 40 creche users and a study of attendance registers. The main conclusions are: (i) the creche serves more to retain existing staff than to recruit new employees; (ii) an increasing proportion of users are in part-time employment; (iii) the level of subsidy averaged about 80 per cent over the last few years; and (iv)

alternative forms of day care of a comparable standard were not available for children under three years old.

SPECIAL CLASSES OF STAFF

MEDICAL STAFF

See also Abstract Nos. 1525, 1604, 1617

1527. RICCI, Edmund and TESSARO, Edward. **Medical direction in skilled nursing facilities.** Hyattsville, Md., National Center for Health Services Research, 1979. v, 68pp. (NCHSR Research Summary Series; DHEW Publication No. (PHS) 79-3223)

This study examines how 1976 United States regulations requiring skilled nursing facilities to appoint a physician as medical director are being observed and how they are affecting the work of nursing homes. In particular, the objects were: (i) to design and conduct a survey of certified skilled nursing facilities indicating the extent to which they fulfilled the requirement for medical direction, the methods used to provide medical direction and the characteristics of facilities unable to comply with the requirement; (ii) to characterize the physicians who served as medical directors and to describe their activities; and (iii) to identify and describe in detail arrangements for medical direction so far developed. A postal questionnaire, a telephone survey and two-day visits to 21 nursing homes provided the data for the study. The authors conclude that the vast majority of specialized nursing homes have provided some form of medical direction and that the concept of medical direction could prove to be an effective force in improving patient care; barriers to implementation are: (i) the reluctance of qualified physicians to assume the role; (ii) confusion concerning the actual role of the medical director; (iii) administrative problems such as excessive paper work and inadequate reimbursement; (iv) limitations in the time physicians have to devote to the tasks assigned to the medical director; and (v) reluctance by medical director physicians to undertake monitoring activities.

NURSING STAFF

See also Abstract Nos. 1518, 1522-1524, 1557, 1587, 1589, 1592, 1596, 1602, 1606, 1629, 1633

1528. RIEHL, Joan P. and ROY, Callista. **Conceptual models for nursing practice.** 2nd edition. New York, Appleton-Century-Crofts, 1980. xvi, 416pp. bibliogs. ISBN 0 8385 1200 3 £8.15

A conceptual model for nursing practice is defined by the authors as a systematically constructed, scientifically based and logically related set of concepts which identify the essential components of nursing practice together with the theoretical bases for these concepts and the values required in their use by the practitioner. In particular, the following viewpoints are important: assumptions, values, goals, the patient as recipient of nursing care, actor's role, source of difficulty, intervention focus and mode and intended and unintended consequences. Three types of conceptual models are distinguished and discussed: developmental, systems and interaction. The application

of each type in the clinical setting is illustrated, and a final section considers the combination of the three models and the possibility of a unified model of nursing. Most of the book's 33 chapters contain bibliographies.

1529. MARRINER, Ann. **Guide to nursing management.** St. Louis, Mo., London, C. V. Mosby, 1980. xiv, 242pp. bibliogs. ISBN 0 8016 3121 1 £5.75

This book is designed to teach nursing students the management process and to supply the practising nurse with practical information about nursing administration. Subjects covered are: (i) planning and decision-making, with a section on budgets; (ii) organizational structure, contents and change; (iii) staff, including selection, allocation and hours of work; (iv) leadership, personnel management, conflict and communication; and (v) control, evaluation, discipline, industrial relations, programme evaluation and quality assurance. A bibliography is included.

1530. BROWN, Sylvia T. and LEE, Belinda T. **Imogene King's conceptual framework: a proposed model for continuing nursing education.** *Journal of Advanced Nursing*, Oxford, 1980, Sept., vol. 5, no. 5, pp. 467-473.

Imogene King's conceptual framework for nursing consists of four major concepts: social systems, health, perception and interpersonal relations. Incorporated into three distinct levels of operation, individuals, groups and societies, these major concepts represent King's view of the dimensions of nursing. This paper presents a proposed model for continuing nursing education based on this framework. The rationale for using it is threefold: (i) the concepts are relevant to every nursing situation; (ii) the interacting levels of operation depict a reciprocal relationship between human behaviour and the environment; and (iii) the triad of elements—continuing nursing education, nursing practice and nursing research—are interrelated in the nursing profession. The authors contend that this approach to continuing nursing education is beneficial to participating nurses, the health care consumer, and to the advancement of the nursing profession. Based on its simplicity and flexibility, the proposed intra-systems model described is useful as a systematic guide for continuing nursing education. The authors believe that this proposed model provides an approach for stimulating continued learning, for establishing innovative foundations for nursing practice and for generating inquiry through research. Using this approach in maintaining the educational standards for professional practice will promote change for the advancement of the nursing profession.

1531. SHEAHAN, John. **Some aspects of the teaching and learning of nursing.** *Journal of Advanced Nursing*, Oxford, 1980, Sept., vol. 5, no. 5, pp. 491-511.

The argument on which this paper is based is that the activities of teaching and learning nursing draw on a number of disciplines and fields of knowledge. To support this argument, the following elements in the process of teaching and learning nursing are set out and each one is analysed and discussed: nursing theory; nursing practice; nursing research; curriculum theory; curriculum development; instructional theory; teaching/learning strategies; learning theory; cognitive learning; affective learning; psychomotor learning; social learning; moral learning; and experiential learning. These elements are later put together to give a synthesis of the intended outcomes of the process of nursing education. A list of 60 references to the literature is included.

1532. TOWNSEND, Ian. **The learning resources movement: its relationship to nurse education.** *Journal of Advanced Nursing*, Oxford, 1980, Sept., vol. 5, no. 5, pp. 513-529.

This paper considers the place, position and potential of what is characterized as the 'learning resources movement' in nurse education. It is based on experiences drawn from 10 years' viewing resource use in general and nursing education and, more recently, on observations arising from a two-year research project looking at the growth within the school of nursing of organizational structures for their development. Four preconditions must be met for effective and appropriate use of resources: analysis; staffing; structure; and implications. It is argued that these preconditions and the true potential of the movement are not being realized, the present position being indeterminate and misconceived. The further development of such resources as are and will be available is intricately tied up with the professional development of nursing in a 'chicken-and-egg' situation. The stage has now been reached where the successful development of the one cannot proceed without the successful development of the other. Drawing on a fairy-tale analogy, the learning resources movement is viewed as a powerful tool for seeing through the shining surfaces of what to many are new curricular clothes and dealing with the basic truths of the situation underneath.

1533. CORMAN, John and KINCAID, Barbara, editors. **Nurse practitioners and physician assistants: a research agenda; summary of the proceedings of a conference held June 21-22, 1977, Warrenton, Virginia.** Hyattsville, Md., National Center for Health Services Research, 1979. v, 20pp. (NCHSR Research Summary Series; DHEW Publication No. (PHS) 79-3236)

A conference to consider research and policy issues on nurse practitioners and physician assistants was organized by the National Rural Center, and involved 90 health researchers, practitioners and government policy makers. The conference participants were divided into five task groups to consider: (i) practice setting variations; (ii) reimbursement; (iii) cost containment; (iv) interpersonal communication; and (v) training. Each task force had as a basis for discussion a previously issued research paper and policy paper. The task groups' research agenda and policy recommendations are summarized in this publication, as are plenary session recommendations on reimbursement.

1534. ASHWORTH, Pat. **Nursing process: problems and solutions.** *Nursing Mirror*, Haywards Heath, 1980, Sept. 4, vol. 151, no. 12, pp. 34-36.

Earlier negative or even hostile reactions to the nursing process have been replaced by a considerable amount of interest and enthusiasm. It seems likely that this is because people have tried the following ideas in practice and found them useful: individualized patient care; teaching less experienced staff; making the best use of resources and justifying an increase; and improving job satisfaction. Six principal problems restrict the wider use of the nursing process, despite its potential benefits: lack of motivation; lack of time; alleged lack of staff; inadequate record forms; reluctance or difficulty in coping with change; and alleged antagonism of senior nursing staff. But many nurses in a number of countries are beginning to use the nursing process, motivated to overcome the difficulties by the benefits gained for patients and staff.

1535. Muster für eine landesrechtliche Ordnung der Weiterbildung und Prüfung zu Krankenschwestern, Krankenpflegern und Kinderkrankenschwestern für den Operationsdienst. **[Model Land regulations for the post-basic training of nurses and children's nurses for operating theatre duties: recommendations of the German Hospital Association.]** *Deutsche Krankenpflegezeitschrift*, Stuttgart, 1980, July, vol. 33, no. 7, pp. 421-426.

This paper sets out in detail the recommendations of the German Hospital Association for the post-basic training and examination of nurses for operating department duties. It is in the form of draft regulations. It sets out the conditions under which nurses should be accepted for these duties, the type of hospital where training should take place, the syllabus (involving a minimum of 240 hours theory and 480 hours practice), and the arrangements for, and conditions of, the qualifying examination.

1536. REDFERN, Sally J. **Hospital sisters: work attitudes, perceptions and wastage.** *Journal of Advanced Nursing*, Oxford, 1980, Sept., vol. 5, no. 5, pp. 451-466.

The study reported in this paper attempted to determine the attitudes and perceptions that hospital sisters have towards their work and the relationship, if any, of these attitudes and perceptions to absence, leaving intent and wastage. The sample consisted of 134 sisters, 88 per cent of all sisters in the general nursing division of two hospitals in the West Midlands. The theoretical approach adopted was based on the Minnesota theory of work adjustment and the role stress theory originally developed at the University of Michigan, and the measures used included rating scales developed in these centres. The results indicated that most of the sisters were, in general, satisfied with their jobs, although a substantial minority were dissatisfied with and experienced role conflict and ambiguity from certain features of their working environment. Comparison of leavers with stayers revealed no difference between the groups on intrinsic satisfaction, absence and role ambiguity, but the leavers were less satisfied with intrinsic features of the job and experienced more tension and role conflict than the stayers. The fairly strong 'mobility culture' reported by other research was supported and it was tentatively concluded that after a year or two the job fails to provide the sister with sufficient challenge, and her propensity is to leave for more stimulating work. The implications of this conclusion are discussed.

OTHER PROFESSIONAL AND TECHNICAL STAFF

See also Abstract Nos. 1533, 1634, 1639

1537. CAETANO, Eduardo. **The hospital engineer's role in health care delivery.** *Hospital Engineering*, London, 1980, Sept., vol. 34, no. 7, pp. 16-24.

The principal characteristics of the hospital engineer are: eclectic technical knowledge; permanent availability; professional honesty; integrity of character; objectivity and pragmatism; common sense and adequate thought; perception of problems; methodical work and punctuality; and permanent vigilance. The evolution of the hospital engineer has paralleled that of the hospital, gaining considerable momentum since the Second World War with the increased use of advanced technology in medicine. Hospital engineers can contribute to the improvement of health care delivery through:

better safety; better environmental comfort; better working conditions for staff; adequate selection of equipment; continuity of work; equipment efficiency; permanent vigilance; collaboration in master plans, etc.; collaboration with planners, designers and manufacturers; and good maintenance. Hospital engineers normally enjoy good relationships with other health professionals, but problems in their relationships with administrators may still occur. The hospital engineer has a very active role to play in hospital management and should be a member of the management team. A career structure, specialized training and continuing education are very important for hospital engineers.

1538. BOXERMAN, Stuart B. and ARTHUR, R. Martin. **Matching technical jobs with needs.** *Hospitals*, Chicago, Ill., 1980, July 16, vol. 54, no. 14, pp. 105-106, 111-112.

Selecting a suitable mix of engineers and technicians who can respond to changing technological needs can be a formidable task for the hospital administrator. The skills of the engineer can help in the evaluation of new equipment and the designing of systems. The training of the technician is more practical, making him deft at repair, assembly and wiring. The typical hospital engineer spends much time in the role of technical manager and is not usually a graduate. The biomedical engineer is a graduate with a background of both engineering and life sciences and his post is geared towards research. The clinical engineer has a similar background and typical activities include the design of electrical safety systems and a preventive maintenance programme for equipment. Technicians include the electrician, the electronics technician and the biomedical equipment technician. The administrator should evaluate these sources of engineering and technical skills on a cost-benefit basis. The appropriate complement of staff will depend upon the hospital's range of services and its level of technical sophistication. The job satisfaction of both engineers and technicians depends upon the proper use of their skills.

ORGANIZATION AND ADMINISTRATION

See also Abstract No. 1527

1539. GALVAGNI, William. **Structured evaluation is key to effective planning.** *Hospitals*, Chicago, Ill., 1980, Aug. 1, vol. 54, no. 15, pp. 52-54.

The author outlines several factors needed to make the hospital planning process effective. The planning committee must include representatives from the board of directors, management and medical staff. It must be responsible for developing a published plan for the hospital and for recommending the plan to the governing body. Basic data, such as detailed studies of hospital operations, must be used in the planning process and the opinion of consumers and the community should be sought. Management activities and the allocation of resources should be directed towards the priorities and objectives contained in the plan. The assessment of weakness in the organization is a crucial, if unpleasant, part of the planning process. The key to success in hospital planning is to specify the individuals or groups who are responsible for the plan's objectives. The achievement of these objectives should be linked to the performance and salary review of those concerned. Good hospital planning in the United States can influence the regulations drawn up by health agencies and government bodies.

1540. BANDER, Kay W. **Strategic planning: reality versus literature.** *Hospital and Health Services Administration*, Chicago, Ill., 1980, vol. 25; special issue 1, pp. 7-22.

To complement an evolutionary revision of management practices, Massachusetts General Hospital began early in 1977 to study various organizational approaches to planning for change within the teaching hospital setting. A study of ten selected hospitals was undertaken to relate approaches found in the literature of corporate management in general and hospital management in particular to actual practice, and to improve the understanding of the philosophy and process at work in selected major teaching hospitals. The study was by interview using questions covering: background; current planning and resource allocation methods; multi-institutional involvement; and assessment. Responses to the study are summarized in this paper under the headings: historic patterns and philosophies of strategic planning; current approaches in philosophy and process of strategic planning; adequacy of the current approach; and future outlook. The teaching hospital finds programme planning and resource allocation more difficult to manage than facility planning. There is sufficient evidence to suggest that this situation may improve. If the 10 hospitals are representative, their approaches are likely to be highly individualistic, reflecting major organizational restructuring within the teaching hospital rather than corporate planning in the profit or the government sectors.

1541. RICE, James A. **Systems offer unique prospects for planning.** *Hospitals*, Chicago, Ill., 1980, July 16, vol. 54, no. 14, pp. 68-72.

The increasing use of multi-hospital systems offers unique planning features for United States hospitals. Planning among hospitals in a system follows one of three models: federation, co-operation or corporate. In the federation model, planning is based on each unit's individual objectives, but with the corporate model centralized decision-making is evident. The co-operative planning process is initiated simultaneously at both local and corporate levels. The Health Central System's planning, which uses the co-operative model in a system operating in nine states, is described. The plan helps local hospitals to sustain their own planning processes while, at the same time, co-ordinating local plans to achieve the best use of corporate resources at local community level. Draft plans and copies of 'certification of need' are reviewed monthly by the Health Central's planning council.

ECONOMICS OF HOSPITAL MANAGEMENT

1542. GOLDSMITH, Jeff C. **The health care market: can hospitals survive?** *Harvard Business Review*, Greenwich, Conn., 1980, Sept./Oct., vol. 58, no. 5, pp. 100-112.

As costs rise, United States hospitals will have to compete with other forms of health care delivery by broadening the services offered and developing new distribution systems. Most Americans now belong to a health maintenance organization, which provides complete health care to its members for a fixed fee. In addition, hospitals are the subject of numerous government regulations described in this article. There are a number of strategies hospitals can use in the face of increased competition. These include: (i) competing for physicians; (ii) diversifying into new services, such as

developing out-patient and emergency services away from the hospital and extending day surgery; and (iii) widening the catchment area of the hospital by developing transport systems to bring in patients. Existing examples of all these new developments are described. In 1977 the American Hospital Association issued standards for responsible use of advertising and some large hospitals have promoted their services in this way. Since 1975 the number of hospitals owned or managed by chains has increased from 469 to 765, as a means of reducing the rate of increase in costs. The future of hospital solvency lies in: (i) the growth of multi-hospital planning; and (ii) the expansion of out-patient services.

RUNNING COSTS

See also Abstract Nos. 1519, 1652

1543. COVERDALE, Ian, GIBBS, Richard and NURSE, Keith. **A hospital cost model for policy analysis.** *Journal of the Operational Research Society*, Oxford, 1980, Sept., vol. 31, no. 9, pp. 801-811.

Although the length of stay of hospital patients in Great Britain has decreased steadily in the last 20 years, demand still exceeds supply. It is therefore vital that when new policies and methods of treatment are being considered their costs are forecast as accurately as possible. This paper describes the development of a model of in-patient costs suitable for policy analysis. The model has three components: overhead, hotel and treatment costs. The size of each component is estimated using regression on historical hospital cost and activity data. It is argued that, for certain types of policy analysis, the model provides a better picture of hospital costs than do conventional accounting methods. The application of the model to the following policy issues is described: the consequences of bed closures under conditions of faster throughput; the effect of age on a hospital's costliness; the effects of a hospital's size on its costliness; the cost of single specialty hospitals; and estimating specialty costs.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See Abstract No. 1647

APPOINTMENT SYSTEMS, WAITING LISTS

1544. COTTRELL, K. M. **Waiting lists: some problems of definition and a relative measure of waiting time.** *Hospital and Health Services Review*, London, 1980, Aug., vol. 76, no. 8, pp. 265-269.

With increasing emphasis being placed on reducing the waiting lists for hospital treatment, both in-patient and out-patient, it has become increasingly important that a relative measure be provided that allows districts, or even individual hospitals, to compare their waiting list with others, or with some average or target position. This paper offers suggestions and outlines a method of comparing the waiting list situation over time or between hospitals or districts as required. Problems discussed include the arrangement of Department of Health and Social Security statistical returns, relationship of the waiting list to the resident population and definition of the

waiting list. The method of comparison recommended is to derive an estimate of the expected waiting time of the next person to join the existing queue. In its most basic form the statistic used is:

$$\text{expected waiting time in years} = \frac{\text{number on waiting list}}{\text{number of admissions from waiting list per year}}$$

A more informative derivation of this is also described. A graphical display of the information is described, with examples.

1545. LUMINEAU, Jean-Louis and CHOUTEAU, Yves. Une étude de cas: les attentes pré-opératoires. [**A case study of pre-operative waiting times.**] *Gestions Hospitalières*, Mantes-la-Jolie, 1980, June/July, no. 197, pp. 525-527.

An analysis of pre-operative waiting times in one surgical unit in the 1,200-bed general hospital in St. Nazaire showed that patients were kept waiting for their operations for one of three reasons: (i) lack of technical resources, i.e. an insufficient number of operating theatres; (ii) lack of medical staff; or (iii) medical problems which contra-indicated the operation. It was found that 400 days, or four per cent of the unit's total activity in terms of days, were wasted in this way every year because of a shortage of theatre facilities. The solution proposed was that the number of operating theatres should be doubled.

1546. WHITE, A. **Waiting lists: a step towards representation, clarification and solving of information problems.** *Hospital and Health Services Review*, London, 1980, Aug., vol. 76, no. 8, pp. 270-274.

If money is to be spent on reducing waiting lists it must be directed at specific points of weakness in a department or specialty; use must be made of available information to lead us to these weaknesses. Following the order of a flow pattern, statistics from a surgical specialty for the period January 1976 to September 1979 are used to derive a number of questions and answers on the factors which influence waiting lists. These cover: out-patients (new); new patients seen in out-patient clinics; out-patients (old); in-patient waiting list; bed use; theatre use; and deaths and discharges. Conclusions reached on the basis of the analysis are: (i) fewer deaths and discharges in the specialty coincide with a lower in-patient list; (ii) the out-patient waiting list is much more sensitive to work done with new patients and can be considered in isolation with more confidence than the in-patient list; (iii) reports such as this might be coupled with budgetary and staffing information to aid the work of administration; (iv) consultants and others at hospital level may also find the information useful in their planning work; and (v) health authorities might have been better equipped to make decisions if such reports had been made available to them in the past.

1547. HERPOK, Franz J. and others. **Automated appointment system excels.** *Hospitals*, Chicago, Ill., 1980, Aug. 1, vol. 54, no. 15, pp. 65-67.

The Total Medical Record automated appointment system at Duke University Medical Center, Durham, North Carolina, matches patients with those giving care. The system allows providers of care to control their own schedules with regard to filling the time available and the length of individual appointments. The system also allows staff to insert information into the list of times and to alter any schedule

which has already been drawn up. When a patient requests an appointment, one of three variations is used: (i) an appointment with any provider; (ii) an appointment with a specified provider; and (iii) the next available appointment with the provider already responsible for the patient's care. Because the Total Medical Record allows sequential scheduling, it can provide a patient with consecutive appointments in different service areas. The system avoids severe peaks and lulls in activity, thereby permitting a balanced allocation of resources. Planning for a day's activities is made easier by the printing of a list of the scheduled patients. A holding file stores requests not immediately accommodated and patients are informed when an appointment has been made. Activity reports produced by the system assist hospital management in financial and service planning.

ELECTRONIC DATA PROCESSING

See Abstract Nos. 1547, 1550, 1567, 1608, 1609

INFORMATION SYSTEMS

1548. LENOIR, P. and MUFRAGGI, F. Notes pour la définition d'une politique d'informatique de gestion hospitalière intégrée, médico-administrative. **[An approach to information policy for integrated medico-administrative management.]** *Gestions Hospitalières*, Mantes-la-Jolie, 1980, May, no. 196, pp. 465-469.

The author suggests that any constructive study of hospital information policy requires an examination of: (i) the nature of the hospital enterprise; (ii) trends in hospital medicine; and (iii) trends in data processing. The hospital enterprise contains: (i) units of production of intermediate goods (hotel goods, para-medical goods); and (ii) services with a health effect (diagnostic and therapeutic services). The former includes flows of stocks, staff, accounts and wages which ought to be processed by computer; in the latter, patients' records should be centralized and managed by computer; laboratory activities and patients' appointment bookings should also be computerized. A recent trend in hospital medicine is for the patient to come into hospital for short periods and return home between treatments. Information on his movements therefore needs to be accessible. This trend also has an effect on the organization of the units of production of intermediate goods (laundry, for example). Efforts to achieve closer integration of the hospital into the health care structure of the region mean that the regional hospital could co-ordinate information on resources and health. Trends in data processing—the use of minicomputers, the decentralization of data processing and the use of interactive systems, data bases and networks will all have an effect on the hospital's information policy.

1549. Nouvelle technique d'évaluation de l'activité hospitalière: 'aide a l'orientation médicale d'un etablissement'. **[A new technique for hospital activity analysis: an aid to management of a medical establishment.]** *Gestions Hospitalières*, Mantes-la-Jolie, 1980, June/July, no. 197, pp. 547-549, 551-561.

This article describes a pilot study at the Gustave-Roussy Cancer Institute, the aim of which was to find the missing link between management of resources and the definition of the hospital's objectives. The system of collecting information on

activities and resources and its transformation into financial terms is described in detail. The data are processed quarterly by computer and tables of activity produced for each department. In the department of medicine, for example, the table has three areas: (i) patients and activities; this answers the questions on site of primary lesion, reason for admission, and treatment given; (ii) resources available and used; and (iii) comments of management analysts on the main variations. The possible uses of a system of this kind will be discussed in a later article.

ORGANIZATION AND METHODS, WORK STUDY

See Abstract No. 1629

MEDICAL RECORDS

1550. STRATMANN, William C. **A demonstration of PROMIS: the problem oriented medical information system at the Medical Center Hospital of Vermont.** Hyattsville, Md., National Center for Health Services Research, 1979. iv, 12pp. (NCHSR Research Summary Series; DHEW Publication No. (PHS) 79-3247)

PROMIS, the application of a computer-based information system to the problem-oriented medical record (POMR), is still at an experimental stage. In this research project, two wards at the Medical Center Hospital of Vermont were studied. The objectives of the project were: (i) the comparative assessment of PROMIS with respect to various indices of the process and record of care delivery; and (ii) the descriptive documentation of the background and conduct of the demonstration with particular focus on the behavioural reactions of users of PROMIS. Features of PROMIS include: facilitating co-ordinated, unified medical care; providing a constant guide to common medical practices for each phase of care; warning of contraindicated therapy and drugs; and the ability to accumulate new information and provide ready feedback. The research project established that PROMIS can be used in a general medical ward setting, but that the overall yield of the system observed was only slightly greater than that of the manual system. The author concludes that the potential benefits of the system may not be realized unless a strategy is developed which will: (i) identify the services desired by physicians; and (ii) provide such services at relatively low personal cost of energy, time or inconvenience to the physician.

HOSPITAL ACCREDITATION AND SIMILAR SCHEMES

1551. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS. **Accreditation manual for hospitals.** 1980 edition. Chicago, Ill., Joint Commission on Accreditation of Hospitals, 1979. xxiii, 225pp. $20.00

This manual, first published in 1970, specifies the standards to be met by United States hospitals participating in the voluntary accreditation system organized by the Joint Commission on Accreditation of Hospitals. Subjects covered by the standards

are: anaesthesia services; building and grounds safety; dietetic services; emergency services; functional safety and sanitation; governing body; home care services; hospital-sponsored ambulatory care services; infection control; management and administrative services; medical record services; medical staff; nuclear medicine services; nursing services; pathology and medical laboratory services; pharmaceutical services; professional library services; quality assurance; radiology services; rehabilitation programmes/services; respiratory care services; social work services; special care units; and utilization review. Additional topics considered are rights and responsibilities of patients, general administrative policies and procedures and accreditation procedures and appeal. An appendix lists the changes made since the 1979 manual.

PUBLIC RELATIONS

1552. MILLER, John A. **Marketing basics for hospital managers.** *Hospital Forum*, San Francisco, Calif., 1980, July/Aug., vol. 23, no. 5, pp. 7, 10-12.

This article summarizes what every hospital administrator or manager in the United States should know about the marketing concept and the marketing system. In order to market the institution, hospital managers should: (i) identify the groups of consumers that the organization can serve; (ii) be knowledgeable about current federal and state regulations concerning hospitals; (iii) consider alternative methods of financing certain services; (iv) evaluate the new medical technology; and (v) be aware of competition. Controllable factors in the marketing of hospital services include: (i) regular evaluation of products and services to meet patient needs; (ii) determination of prices; (iii) distribution of services to where they are needed; and (iv) appropriate use of advertising and other means of promotion. Financial managers and hospital administrators need to use the marketing concepts and techniques to achieve the objective of meeting patient needs.

LEGAL AND ETHICAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract Nos. 1598, 1599, 1631, 1638

1553. ALLARD, Ted. **Security in the NHS.** *Hospital and Health Services Purchasing*, London, 1980, April, pp. 109-111.

Queen's Medical Centre, Nottingham, is a developing complex comprising the medical school, school of nursing, 1,400-bed University Hospital, a social centre and district offices; all are on a very concentrated 43-acre site. Security has been placed high on the list of priorities, and constant updating to meet changing situations and commitments takes place within the broad ambit of providing a patient support service and security in the accepted sense of the term. The selection and role of the security officer are discussed. Guards, designated security patrolmen, are employed on a 24-hour rota as a patient-oriented security department. Their functions include duties ranging through traffic control, lock and unlock procedures, routine and random patrolling, assisting with disturbed patients, to escorting cash movements and providing pay point protection. Cost-effectiveness is difficult to evaluate, but reported crime is far less in the centre, despite its size, than in any other sector in the South

Nottingham District. The advantages of an in-house security service compared with a commercial service are discussed.

1554. ABERNETHY, Virginia, editor. **Frontiers in medical ethics: applications in a medical setting.** Cambridge, Mass., Ballinger, 1980. x, 201pp. ISBN 0 88410 710 8

These papers and discussions from a symposium held at Vanderbilt University School of Medicine in February 1979 are concerned with the following topics: (i) choosing styles of dying and living, where it is argued from a viewpoint of ethical relativity that there can be a variety of 'good deaths'; (ii) the possible conflict between the physician's duty to benefit the patient and at the same time to respect his autonomy; (iii) the place of ethical rules in medical decision-making; (iv) a case study discussion concerned with a terminally ill cancer patient; (v) the law and ethics relating to the refusal of medical treatment by competent adult patients; (vi) legal norms and procedures for withholding care from incompetent patients; (vii) resuscitation, and the connection ethical arguments on this subject could have with the issue of euthanasia; (viii) a case study discussion concerning a newly-born infant surviving only by means of a life support system; (ix) the issues of value of life and quality of life in decisions to provide or withhold treatment; (x) the role of a medical ethics consultant in decision-making; and (xi) a case study discussion concerning a disruptive patient.

1555. TRAINI, Robert. **How the health service is plundered.** *Security Gazette*, Bristol, 1980, Sept., vol. 23, no. 9, pp. 21, 23, 25, 27.

Theft from hospitals in Great Britain, vandalism, and violence against staff are increasing. It is suggested that official reports underestimate the value of losses; thefts from staff and patients are not recorded. There are some 200 health districts in the National Health Service, but in the entire service there are only 160 senior security advisers and officers. The experiences of some of these are outlined. Commercial security services are used by some hospitals. There is no central co-ordination of security activities and no accepted standards of professionalism, recruitment, training or career structure. It is suggested that the savings to be achieved by an in-house security organization centrally funded would far offset any extra costs.

1556. HUMBER, James M. and ALMEDER, Robert F., editors. **Biomedical ethics and the law:** 2nd edition New York, London, Plenum Press, 1979. xiv, 658pp. bibliog. ISBN 0 306 40239 4

The articles collected in this volume cover the social problems caused by the revolution in medical technology. The section on death, for instance, has 10 items ranging from existentialism and religion to the allocation of special therapy and resources. The sections are as follows: (i) abortion; (ii) mental illness; (iii) human experimentation; (iv) human genetics; and (v) dying. Each section has a short introduction and an extensive bibliography.

1557. FINCH, John. **Law and the nurse: when are you liable for negligence?** *Nursing Mirror*, Haywards Heath, 1980, Sept. 4, vol. 151, no. 12, pp. 22-24.

This first paper in a series of six considers the law of negligence. The law of negligence is one aspect, indeed a very major aspect, of the law of tort. The three essential ingredients of the tort of negligence are: duty, breach and damages. The law does not

impose liability just because an accident happens. There has to be carelessness which the law will brand as a breach of duty. While it is commonplace that nurses owe their patients a legal duty of care, it is by no means every act which causes someone harm which will amount to a breach of duty. A number of examples are cited to illustrate the aspects of duty, breach and damages.

OTHER SPECIAL ASPECTS

1558. GIBSON, I. R. L. **Commissioning hospital projects—management or mismanagement.** *Hospital and Health Services Review*, London, 1980, Aug., vol. 76, no. 8, pp. 275-276.

The most common approach to commissioning is to think of the tangible tasks leading to the opening of the hospital—equipping, staffing, operational policies, etc. It is possible, however, to analyse commissioning management in terms of processes and problems, thus looking at the subject from an entirely different perspective. No one management system is likely to be appropriate for all hospital projects, but there are a number of factors applicable to all projects which should be considered. These include: (i) the commissioning task must not be too narrowly-conceived at the outset; (ii) all involved must be aware that the commissioning process is, or should be, characterized by innovation and change; (iii) commissioning goals may not be met because of failure to define in quantitative terms the results expected and of resistance to change; (iv) conflicts of priority are influenced by the role of power and influence and by political behaviour; and (v) informal evidence of success, that is the opening of the hospital, does not obviate the need for proper evaluation. The commissioning task may be summarized as decision-making, communication and control.

1559. RICE, James A. **Interinstitutional planning process, part 1: freestanding hospitals.** *Hospitals*, Chicago, Ill., 1980, July 1, vol. 54, no. 13, pp. 51-53, 56.

This article discusses the planning of organizational arrangements between two or more freestanding hospitals in the United States. Planning processes involving several institutions should be carried out by a committed and informed group who can decide what inter-hospital arrangements are feasible. Hospital managers can guide their efforts by studying recent theories in the field of interorganizational research. The recent growth in multihospital arrangements show that: (i) there are many ways in which hospitals can relate to one another; (ii) hospital staff must be educated in the idea of shared schemes; and (iii) all those involved must be kept informed of the progress of such schemes. Managers who wish to take part in inter-hospital planning must not only study the products but also the process of such planning.

FINANCE AND ACCOUNTING

FINANCE

1560. WILLIAMS, Stephen J. and others. **Regionalization in the Veterans Administration health care system: rhetoric and realities.** *Journal of Health Politics, Policy and Law*, Durham, N.C., 1980, vol. 5, no. 1, pp. 98-119.

Criticisms of the United States Veterans Administration health care system have

centred around the inflexibility of the system's response to changing service requirements. VA hospitals use traditional budgeting and planning processes; new programmes and projected increases in work load are added to the previous year's budget to yield the budget for the succeeding year. Since these activities occur on an individual institution basis, there is little effort to plan co-operatively between hospitals or to reassess the fundamental allocation of resources on veteran needs. Over the past two years, the VA has devised a programme of regionalized budgeting and planning. The publicity surrounding VA regionalization reflects the idealized potential of shared resources and joint planning within each of the newly created VA medical districts. The reality of the programme, however, when examined on a national basis and illustrated by an in-depth study of five hospitals in one district, indicates that there has been little use of resource allocation methodology and that few planning resources have been allocated to this effort. As a result, the district programme is a collation of individual hospital budgets, and plans to yield the district budget and plans. Regionalization is unlikely to succeed in any meaningful manner within the VA unless further changes occur in district resource allocation methods.

COSTS

See also Abstract Nos. 1568, 1569, 1629

1561. HUGHES, Edward F. X. and others. **Hospital cost containment programs: a policy analysis.** Cambridge, Mass., Ballinger, 1978. xiv, 153pp. ISBN 0 88410 705 1 £11.00

Concern at the cost of medical care in the United States has led to two recent measures; the government's Hospital Cost Containment Act and Senator Talmadge's Medicare and Medicaid Administrative and Reimbursement Reform Act. Based on an analysis of these proposals, the authors advance their own hospital cost containment programme. They propose: (i) a national revenue limit should be applied to both in-patient and out-patient programmes of a hospital; (ii) the national revenue limitation should be allocated to Health Systems Agencies (HSAs) based on adjustments for the types of hospital they contain; (iii) allocation of the HSA allowed revenue increase among hospitals should be approved by newly created state health reimbursement boards; (iv) the allowed revenue increase should be adjusted for changes in admissions; (v) hospitals where cost increases are lower than the allowed revenue limit should receive an incentive payment; (vi) exceptions to the revenue limitations should be allowed in certain areas, e.g. staff costs; (vii) a uniform accounting and reporting system should be established for all hospitals; (viii) a national limit for hospital expenditure should be set each year; (ix) capital expenditure proposals should be co-ordinated by HSAs; (x) decertification of technology, services and facilities, with corresponding revenue adjustments, should be the responsibility of HSAs.

1562. ABERNETHY, David S. and PEARSON, David A. **Regulating hospital costs: the development of public policy.** Ann Arbor, Mich., Aupha Press, 1979. xix, 228pp. ISBN 0 914904 36 1 £13.95

This study addresses three subjects: (i) rising costs in United States health services;

(ii) legislative attempts to combat this problem in 1977 and 1978, most notably by the Hospital Cost Containment Bill; and (iii) the progress and ultimate failure of the legislation in Congress. Theories of hospital expenditure considered by the authors to analyse the problem and to measure the potential effectiveness of the proposed legislation are: labour cost-push; lagging productivity; general cost-push inflation; technological improvements and scientific progress; excess capital expenditures; cost reimbursement; demand-pull inflation and the growth of third party payments; and supply-induced demand. Earlier government efforts to contain hospital costs and the voluntary cost control programme initiated by the American Hospital Association are also described.

1563. MONTFORT, Augustinus Petrus Wilhelmus Paulus van and SPAAN, J. M. Kostenatlas: regionaal overzicht van ziekenhuiskosten in Nederland. **[Cost atlas: regional survey of hospital costs in the Netherlands.]** Utrecht, Nationaal Ziekenhuisinstituut, 1979. 21pp., 3 fold. maps. bibliog. (NZI Publikatie 79.183) F.11.50

This survey for 1976 was carried out in the 24 health care regions of the Netherlands. The regions vary considerably in size and a distinction is made between their geographical population and their adherent population, which are those who attend the hospitals of the region. The report consists of tables with explanatory text and a reference to the averages for the country as a whole, giving for each region: description and size; costs per region, per inhabitant and per hospital day; number of staff per 100 inhabitants and per 100 beds; costs, salaries and social costs per staff member; number of beds, bed occupancy, number of hospital days and admissions, average length of stay; number and types of specialists in different hospitals and per 100,000 inhabitants. Also given are: average costs per hospital day during 1976; average number of staff per 100 beds; and average costs per one member of staff. It was noticed that costs per hospital day per inhabitant varied considerably for the different regions, but possible reasons (e.g. numbers of beds, salaries) are not pursued. A further study into the regional cost structure is recommended. The paper includes 13 tables, a list of literature and three maps.

HOSPITAL ACCOUNTING

1564. ALLCORN, Seth. **Internal auditing for hospitals.** Germantown, Md., London, Aspen Systems Corporation, 1979. xi, 213pp. ISBN 0 89443 163 3 £14.75

The purpose of this book is to advocate internal auditing in all hospitals, regardless of size. The author argues that internal audit can help hospitals improve efficiency and effectiveness, identify wastes and poor administrative practices and recommend changes in operating procedures to enhance internal control of all business and patient care activities. Basic readings in theory and practice and detailed discussions of practical applications are given. Internal auditing in academic medical centres is considered in a separate section. Checklists of procedures for the hospital auditor are given for the various stages of the operation.

SUPPLIES AND STORES

PURCHASING

1565. MONTAGUTI, Sergio. Esperienze di acquisti in comune realizzati da enti ospedalieri della regione Emilia-Romagna. **[Experiences with bulk buying by hospitals in the Emilia-Romagna region.]** *Tecnica e Metodologia Economale*, Firenze, 1980, May/June, vol. 19, no. 3, pp. 167-169, 171-174.

The method currently employed by hospitals in the Emilia-Romagna region for bulk purchases of material such as X-ray plates, drugs and linen is described. For photocopying machines, for example, a questionnaire concerning requirements was circulated to the 90 institutions concerned; 65 replied. These replies were analysed and firms which could supply machines which used ordinary paper were invited to provide lists of machines. The costs of these were compared and a prospectus containing the findings was prepared and sent to the hospitals with an account of the negotiations. Savings of up to 20 per cent of the cost of materials have been achieved by this method. The author would like to see the introduction of standardized diets in the hospitals in the region, and also standard maintenance and insurance contracts, basic standards for equipment, the standardization of linen, the introduction of a joint pharmaceutical handbook and the provision of economic structures for joint services such as laundry.

ECONOMIC USE OF SUPPLIES, DISPOSABLES

See Abstract Nos. 1581, 1582

STORES

1566. GRAYSON, Hazel. **Little fish and large pools.** *Health and Social Service Journal*, Basingstoke, 1980, Sept. 5, vol. 90, no. 4709, pp. 1169, 1170.

The Department of Health and Social Security continues to encourage the idea that centralization, for such things as supplies and linen services, is both economically and operationally sound. The Medical Architecture Research Unit, Polytechnic of North London, has studied a number of new hospitals which were designed to receive services from an off-site source. The problems revealed include: (i) inadequate space for storage and goods handling within the hospital building, particularly when some supplies are still being delivered to hospitals in bulk; (ii) greater difficulty in placing and following up orders; and (iii) shortage of supply and damages, particularly in respect of linen.

1567. LONGLEY, D. E. **Apple to X-ray, via computer.** *Health and Social Service Journal*, Basingstoke, 1980, Sept. 12, vol. 90, no. 4709, pp. 1197, 1199, 1200.

Barnet Area Health Authority accepted in principle the centralization of the area's supply function in March 1975. Suitable premises were found in a local warehouse development comprising 24,000 square feet of floor space 21 feet high. A new staffing structure was agreed in February 1976 and the new area stores opened on 1 October 1976 for all items from apples to X-ray films, except drugs and building and engineering

stores. The main activities involved in completing this work in the time scale are listed. In 1978 the authority approved in principle the early introduction of a dedicated minicomputer for the area stores. A Redifon 850 computer was ordered in February 1979 and the system went 'live' on 4 July 1979 with three sections of the stores; other sections were added until the first phase was completed on 2 February 1980. This provided a basic system of recording stock receipts and issues on charging issues to budget holders. The second phase, completed on 8 July 1980, provided for the printing and processing of orders and part deliveries, the retention of unsatisfied stock requisitions for subsequent action on receipt of stock, an analysis of consumption and a buying record history.

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

1568. BERKMAN, Jerome. **Food service needs controls to contain costs.** *Hospitals*, Chicago, Ill., 1980, March 16, vol. 54, no. 6, pp. 79, 80, 82.

This article discusses methods of cost control used in the food service department at Cedars-Sinai Medical Center, Los Angeles. One successful food quality control system is based on surveys of patients' preferences. A weekly evaluation of food purchases is arrived at by dividing the weekly expenditure for each food category by the number of meals served. The cost is then compared with the cost one year previously to measure the effect of the department's cost containment programme. Group purchasing systems are cost effective and purchases should be made according to need and not hoarded. Recipes should be followed carefully and portion control enforced in order to avoid waste. To control labour costs, a time should be allocated for certain tasks, allowing the food service director to calculate a standard time needed to accomplish a set of service units. By comparing the total number of work hours with the standard, he can establish a proficiency rating and increase or decrease the number of staff as necessary. Another key factor in cost containment is the director's use of an audit checklist which includes detailed questions regarding management controls of both staff and materials.

1569. BRYANS, William. **Health care catering management.** *Public Finance and Accountancy*, London, 1980, Sept., pp. 28-30.

The problems of catering for patients are discussed in terms of a profile for financial control. The basic information made available to catering managers should be simple; a table shows the type of material which may best initiate dialogue between finance officers and catering managers. A variety of supplementary data is available. It falls into three categories: actual costs; standards; and comparative costs.

1570. ZACCARELLI, Herman E. **Contracting for food service management.** *Hospitals*, Chicago, Ill., 1980, Aug. 1, vol. 54, no. 15, pp. 71-73.

This article presents guidelines to help hospital administrators: (i) to choose a food service company to provide their hospital with good quality food; and (ii) to maintain control over the company's food policies and procedures. A company should

be selected not only on grounds of cost but from evidence of their ability to give good service. The term of the contract with the company should not exceed two years and a performance bond must be included. The company must comply with all tax laws and laws regarding food service facilities. Menus should be submitted to the hospital for approval and the portion size of each item should be established by the hospital and the food company together. Frequency of service and the price structure should be established during the negotiation period. The administrators must understand the staff policies and practices of the company, including: (i) wage scales to be paid; (ii) job descriptions; and (iii) provision of adequate staff to provide a satisfactory service. The hospital must have a total financial accountability system from the food service company and the operation of the contract must be closely supervised.

1571. PANNBACKER, Beth and others. **Fat-modified menu's ongoing success noted.** *Hospitals*, Chicago, Ill., 1980, July 16, vol. 54, no. 14, pp. 95, 97-100.

In 1972, St. Joseph Hospital, Chicago, introduced low fat, selective cycle menus for patients, staff and visitors. The standards used for the menu plan were based on the Chicago Heart Association's Nutrition Education Project. The food service departments put all dishes into categories according to their fat and cholesterol content, and in groups ranging from approved, modified and occasional foods to those not to be used at all. The menus were planned and introduced jointly by Chicago Heart Association staff and the hospital staff over a six month period. The resistance of the hospital's food service staff diminished as they came to understand the new menus and make their own suggestions. The project was promoted with assistance from the education and public relations departments. Posters, pamphlets and flyers were used to explain the scheme. The current menu is a 12-day selective cycle with a fixed week-end menu and the number of low fat items has been increased. Long term follow-up shows continued use and acceptance of the modifications.

1572. KOBLISCHEK, Sighard R. Essen à la Carte für Kinder—St. Vincenz Krankenhaus Limburg. **[A la carte eating for children: St. Vincent's Hospital, Limburg.]** *Krankenhaus*, Stuttgart, 1980, Aug., vol. 72, no. 8, pp. 296-297.

As part of a campaign to minimize hospital trauma for children, St. Vincent's Hospital in Limburg has introduced an à la carte system for children's meals in the 45-bed children's unit. The child or his parent makes his choice from a brightly coloured menu card, which he is allowed to keep; the nurse then marks the numbers of the dishes chosen, together with the size of portion required, on his order card. All the order cards have to reach the kitchen by 8.30 a.m. at the latest. The system has helped to make meal time a pleasanter part of the day and has markedly reduced the quantity of left-over food.

HYGIENE IN THE HOSPITAL

HOSPITAL INFECTIONS

1573. POLK, B. Frank and others. **An outbreak of rubella among hospital personnel.** *New England Journal of Medicine*, Boston, Mass., 1980, Sept. 4, vol. 303, no. 10, pp. 541-545.

In the spring of 1979 an outbreak of rubella occurred among staff at the 489-bed

New England Deaconess Hospital, Boston, Mass. At least 47 employees were affected, one pregnancy was terminated and 475 working days were lost. Epidemiological investigation suggested a common source: a catering worker was identified as the probable index case. Serum samples of 12 per cent of women employees were negative for rubella antibody at the time of the outbreak. Neither a history of rubella nor a history of immunization with rubella vaccine was reliable in the prediction of the presence or absence of immunity. Two-thirds of all hospital staff were immunized through a voluntary mass immunization programme, but the response of physicians to the programme was disappointing. Outbreaks of rubella that occur in hospitals with prenatal clinics are of special concern. Testing of all staff for rubella antibody and immunization of those found to be seronegative should be considered.

PREVENTION AND CONTROL

1574. SCHAEFER, Frederick, LIBERMAN, Daniel and FINK, Richard. **Decontamination of a centrifuge after a rotor explosion.** *Public Health Reports*, Washington, D.C., 1980, July/Aug., vol. 95, no. 4, pp. 357-361.

Centrifuge accidents involving infectious disease organisms are a health hazard to the whole hospital. The authors describe the decontamination procedures carried out when a rotor in a centrifuge containing such organisms exploded. The centrifuge was sealed off by the polythene canopy. By placing an electric frying pan of boiling water under the canopy, 18 grams of paraformaldehyde flakes were vapourized. The pan was then disconnected and the canopy kept sealed for one hour. The canopy was then ventilated for 20 hours, the exhaust ventilation being provided by a fume hood. The centrifuge rotor and chamber were destroyed by the explosion, which might have caused serious injury. Centrifuge accidents result from equipment failure or operational error. The former can be minimized by a preventive maintenance programme and the latter by adequate staff supervision and strict adherence to the operation manual.

1575. HAMMOND, James B. and POTIN, James B. **Laboratories and hospital infections: a hands-on role.** *Lab World*, Philadelphia, Pa., 1980, July, vol. 31, no. 7, pp. 40-42.

This discussion focuses on two aspects of a comprehensive and effective infection control programme: the interrelationships between the clinical microbiology laboratory and patients; and the obligation of the hospital to laboratory staff through its staff health service and the infection control committee. The objective is support of the recognition, diagnosis and management of infectious diseases in hospital. The aspects discussed include: proper use of the laboratory; quality control in the laboratory; liaison between the laboratory and the infection control committee, with particular reference to the information the former should provide; and protection of hospital staff from the risk of infection.

1576. VERDON, Patricia and TUKE, Winifred. **A district hospital disinfection unit.** *Nursing Times*, Basingstoke, 1980, Oct. 9, vol. 76, no. 41, pp. 1799-1801.

Because the central sterile supply department serving the Portsmouth district

was unable to take on the added role of a hospital sterilizing disinfection unit, a pilot scheme was set up to clean and disinfect all suction tubing, starting with the maternity departments. The scheme began in 1972 and initially employed one part-time female orderly using a small vacant sluice room. It was soon apparent that there was a demand for a much wider service for all the district's hospitals. The service started in October 1976 in a disused mortuary to provide: (i) a main room for the washing, processing and reassembling of the equipment; (ii) two formalin cubicles with built-in racks for exposure of items to formalin vapour; (iii) an open area for hosing and washing down oxygen tents, water and ripple beds, etc.; (iv) a small area housing an autoclave; and (v) staff cloak and rest room. The unit is now staffed by a supervisor, two intrument orderlies and a driver. The cost of setting up the unit was £7,000. Details are given of the service now provided to all hospitals in the district.

HYGIENE IN THE OPERATING THEATRE

1577. MEFFEN, Karen. **The good and the bad.** *Nursing Mirror*, Haywards Heath, 1980, Oct. 9, vol. 151, no. 15; supplement, pp. v-vii.

Three different types of surgical filtration mask were compared to find out the difference in efficiency when a good and bad mask technique was used. Volunteers, all used to wearing surgical masks, were asked to select the mask they normally wore and found most comfortable and given instructions regarding its use. Each type of mask was blood agar plated after being worn for five, 15 and 30 minutes and one hour. The procedure was repeated without the instructions being given. Fifty questionnaires on the masks and 50 on mask technique were distributed to the volunteers; 38 and 45 respectively were completed. The experiments showed that a bad mask technique means a highly contaminated mask which, in turn, may contribute to wound infections. Of the three types of mask compared, the two with synthetic filter media appeared to be more efficient than the conventional muslin mask. Even using good mask technique, the muslin mask began to allow respiratory organisms through after being worn only for one hour.

1578. BELKIN, Nathan L. **Textiles as aseptic barriers: the past, present, and future.** *Medical Instrumentation*, Arlington, Va., 1980, July/Aug., vol. 14, no. 4, pp. 233-236.

Operating room sheets and gowns have changed since 1900 to reflect changing attitudes towards textiles as aseptic barriers. A loosely woven, all-carded cotton, type 140 muslin used to be considered acceptable, but by the early 1950's it was realized that this material did not act as a bacteriological barrier when it became wet, as often happened during operations. New non-woven, man-made materials were introduced which were non-absorbent and disposable. A number of new woven fabrics were also introduced and the re-usable versus disposable issue still continues. In 1978 a new standards committee was set up in the United States to study the problem of aseptic barriers. The aims were: (i) to develop standards for acceptable microbial barriers between clean and unclean areas; and (ii) to find a material which provides both comfort and non flammability. Both these factors are hard to achieve because

they depend upon the use and environment to which the fabric is exposed. A material's ability to remain sterile in addition to establishing a sterile field must also be considered.

1579. RUTHERFORD, William H. and SPENCE, Roy A. J. **Infection in wounds sutured in the accident and emergency department.** *Annals of Emergency Medicine*, Irving, Tex., 1980, July, vol. 9, no. 7, pp. 350-352.

While there are many reports on infection rates in wounds made in operating theatres on in-patients, information is scarce on wound infection in out-patients treated in accident and emergency departments. Of 500 consecutive patients whose wounds were sutured in the accident and emergency department of the Royal Victoria Hospital, Belfast, 65 did not report for removal of sutures; information on all but 15 of these was obtained by correspondence. Severe infection occurred in 2.47 per cent of the 485 patients and there was redness and swelling, possibly from infections, in 4.53 per cent, making a total of seven per cent of patients with signs of inflamation. The results are compared with previous studies and the techniques and problems of suturing wounds in accident and emergency departments are discussed.

STERILIZATION

See also Abstract No. 1583

1580. ASSOCIATION FOR THE ADVANCEMENT OF MEDICAL INSTRUMENTATION. STEAM STERILIZATION COMMITTEE. **Good hospital practice: steam sterilization and sterility assurance (proposed).** Arlington, Va., Association for the Advancement of Medical Instrumentation, 1979. x, 48pp. bibliog. (AAMI SSSA-P 4/78)

This standard of practice was developed by the Steam Sterilization Subcommittee—Hospital Practices Working Group of the AAMI Sterilization Committee. The purpose of the guidelines is to promote sterilization employing a steam sterilizer and the assurance that sterility of processed items is maintained to the point of use in hospitals and similar health care facilities. Topics considered include: (i) pre-sterilization recommendations; (ii) sterilization procedures; (iii) post-sterilization recommendations; (iv) care and maintenance of sterilizers; and (v) quality control.

1581. STANDRING, J. A. **Disposable gloves: a study of the uses, relative advantages and cost of disposable gloves.** *Journal of Infection Control Nursing*, Basingstoke, 1980, Aug., no. 14, pp. 15, 17, 18.

Following complaints of potential cross-infection hazards from plastic gloves used in wards and departments, a study was made of two types of disposable latex glove. As a result one of these was selected for use. Some months later, administrators became concerned at the high expenditure on disposable gloves. It was found that large quantities of surgeons' sterile gloves were being used in all wards and departments for many procedures in which the cheaper plastic examination glove had previously been used. A list of procedures in which gloves could be used was compiled, based on existing practices, a specific type of glove being recommended for each procedure. After three and six months, staff using gloves were invited to complete questionnaires

on the gloves. Summaries are given of the comments on unsterile plastic gloves, unsterile latex gloves and sterile latex gloves. The attributes of the ideal glove, based on users' comments, are listed. As a result of the study the following recommendations were made: (i) a policy for the use of disposable gloves be formulated; (ii) use of plastic examination gloves be discontinued, except for very simple procedures of short duration; (iii) manufacturers be informed of the users' requirements and comments; (iv) disposable procedure gloves should only be used by the medical and nursing staff; and (v) disposable latex procedure gloves should replace the use of sterile surgeons' gloves for ward-based procedures.

1582. BUCKLES, A. M. **How should we dispose of our used needles and syringes?** *Journal of Infection Control Nursing*, Basingstoke, 1980, Aug., no. 14, pp. 5, 6, 8, 11.

Needles and syringes are being used throughout hospitals in an ever-increasing volume; the disposal of these hazardous products presents a problem and the usual method now in use is inadequate. Four different boxes, manufactured for the disposal of needles, syringes and other sharp objects, were evaluated against a fixed set of functional requirements thought necessary for a safe, acceptable sharps box. The criteria used were: satisfactory level of resistance to damage on penetration; acceptable size and holding capacity; minimal risk of any seepage of blood products; safe device for sealing box when full; safe and easy to use carrying handle; distinctive labelling giving easy identification; safe and easy to use aperture for receiving sharps; quick and easy assembly of box; easy storage; satisfactory shape; burnable; and inexpensive. Staff using the boxes graded their performance in respect of each of these criteria. Detailed results and an overall score are given and one of the products is recommended for use.

AIR HYGIENE

See also Abstract No. 1584

1583. SAMUELS, Tom M. and EASTIN, Mary. **ETO exposure can be reduced by air systems.** *Hospitals*, Chicago, Ill., 1980, July 1, vol. 54, no. 13, pp. 66-68.

Adequate ventilation and air changes can reduce staff exposure to ethylene oxide in sterilization rooms. Active exposure can be controlled by the use of local exhaust devices or cycle modifications, using either continuous or pulsating chamber purges. Staff experience passive exposure to vapours when a sterilizer is unloaded. This can be controlled by good procedures and maintenance for gas containment, and by adequate room ventilation. It is important that air changes and air circulation be maintained at a high level where ethylene oxide gas supplies, sterilizers or aeration cabinets are located. Ventilation systems should be checked regularly. About half of the 171 hospitals studied changed the air less than 10 times per hour, which would seem to be barely adequate. All ethylene oxide sterilizers must be vented to the outside, either to an outside wall, or, in the case of large, built-in sterilizers, by means of floor drains. If the ventilation of an entire sterilization area cannot be improved, it may be wise to isolate the sterilizer by a partition and install a local exhaust device.

SAFETY MEASURES

HAZARDS, GENERALLY

See also Abstract Nos. 1574, 1605

1584. NOTANI-SHARMA, Prem. **Little-known mercury hazards.** *Hospitals*, Chicago, Ill., 1980, July 1, vol. 54, no. 13, pp. 76-78.

Sources of exposure to mercury in hospitals include: (i) the thermometer holders and heating element unit in neonatal incubators; (ii) the central supply department, where contamination can be traced to broken thermometers; and (iii) the equipment repair department where broken sphygmomanometers are reactivated. To measure mercury levels in the air surrounding equipment repair staff, monitoring should be carried out using mercury dosimeters. Procedures should be set up for decontaminating equipment and contaminated areas, as well as for minor spills such as broken thermometers in wards. A spill team should be selected and necessary equipment for handling a spill and disposing of contamination procured. This equipment should include: (i) mercury vacuum cleaners; (ii) disposable personal protective equipment; and (iii) a water soluble mercury decontaminant. Appropriate signs for identifying contaminated areas should be made. Mercury thermometers in neonatal incubators should ideally be replaced by non-mercury types.

FIRES AND FIRE PREVENTION

See Abstract Nos. 1511, 1603

RADIATION HAZARDS

1585. RICHTER, Linda L. and others. **A systems approach to the management of radiation accidents.** *Annals of Emergency Medicine*, Irving, Tex., 1980, June, vol. 9, no. 6, pp. 303-309.

The fundamentals of radiation, its biological effects, exposure guide limits and measurement of exposure are outlined. Management of radiation accident patients should have a multidisciplinary approach that includes all health professionals as well as members of public safety agencies. Emergency plans for radiation accidents include detection of the ionizing radiation, patient evacuation, resuscitation and decontamination. The resuscitated patient should be transported to a radiation control area located outside but adjacent to the emergency department. Ideally this area is reached through an entrance separate from that used for the main flow of daily emergency department patients. The hospital staff, provided with protective clothing, dosimeters and preprinted guidelines, continue the resuscitation and definitive care of the patient. This systems approach to the management of radiation accidents may be tailored to meet the specific needs of other emergency medical systems.

THE PATIENT

1586. DOREMUS, Harvey D. **DRGs may be raising false expectations.** *Hospitals*, Chicago, Ill., 1980, Aug. 1, vol. 54, no. 15, pp. 47-51.

Diagnostic related groups (DRGs) were developed in the United States to classify patients into diagnostic categories in order to determine a standard length of stay for utilization review purposes. From a data base of 83 major diagnostic groups, 383 DRGs were formed that were clinically and statistically related to length of stay. DRGs can be used for: (i) budgeting; (ii) planning at both institutional and regional levels; (iii) utilization review on a regional basis; and (iv) the development of a prospective reimbursement system based on a hospital's mix of patient cases. A method by which DRGs can be used to calculate a maximum reimbursement for both individual and groups of hospitals is described. However, the system has certain limitations. These include: (i) average patient lengths of stay differ considerably by geographical area; (ii) length of stay is not by itself an accurate indication of treatment costs; (iii) the variables used in developing DRGs were limited by the data available; and (iv) diagnoses recorded in patients' medical records are not always accurate. DRGs are only useful if: (i) they are applied to a defined patient population; and (ii) they are up-dated periodically to reflect changes in patient care.

WELFARE OF THE PATIENT

See also Abstract Nos. 1641, 1649

1587. HAMES, Carolyn Cooper and JOSEPH, Dayle Hunt. **Basic concepts of helping: a wholistic approach.** New York, Appleton-Century-Crofts, 1980. xii, 260pp. bibliogs. ISBN 0 8385 0558 9 £6.20

This book is concerned with the role and responsibilities of professional helpers, especially nurses. It contains chapters on: adaptation; culture; threat; problem management; helping; communication; therapeutic communication; barriers to effective communication; learning; and group dynamics. It also serves as a teaching aid, providing exercises and games. Each chapter contains references to the literature.

1588. Klachtenbehandeling en patiëntenrechten. **[Complaints handling and patients' rights.]** *Ziekenhuis*, Utrecht, 1980, July 16, vol. 10, no. 13/14, pp. 389-394.

The subject of complaints handling and patients' rights was discussed at a meeting of the Netherlands National Hospital Council. Patients' rights and duties are still insufficiently realized by both patients and staff. Duties concern co-operation with medical staff, giving proper information and following medical advice; rights concern treatment, care, free choice of hospital, information, damages and lodging of complaints. Patients often have little confidence in complaints boards composed of hospital staff. Such boards should consist of independent experts or a balanced composition of hospital staff and patients' representatives and should have a proper address for receiving complaints and a simple, reasonably fast and not too expensive complaints procedure. A general change of mental attitude in favour of patients'

status should be developed. In nursing homes, complaints of chronically ill patients must often be made on their behalf by representatives, such as relatives, ombudsmen and committees. This procedure should be clearly laid down with a well manned system of inspection. For independent investigation of complaints special court chambers are suggested which specialize in health legislation. Three stages are recommended for hospitals: the patients' confidential representative, an (internal) committee for patients' care and an (external) committee to deal with complaints. Registration should be obligatory. Patients after discharge might be asked for their opinion on the quality of treatment. The extra costs involved in implementing the suggested recommendations were noted.

1589. LAWSON, Katherine. **Listening to patients.** *Nursing Times*, Basingstoke, 1980, Oct. 9, vol. 76, no. 41, pp. 1784-1788.

Listening is fundamental to everyday basic communication. This paper offers guidance, with illustrations, to nurses on: (i) the techniques of active listening; (ii) use of open-ended questions; (iii) reflections; (iv) opposite questions; (v) listing; (vi) directive techniques; (vii) double-edged questions; and (viii) summarizing.

1590. HATTINGA, J. C. M. and BRINK, M. van den. Zelfzorg en mantelzorg in het verpleeghuis. **[Independence and caring for others in nursing homes.]** *Ziekenhuis*, Utrecht, 1980, July 16, vol. 10, no. 13/14, pp. 400-401.

Looking after oneself and caring for others are basic human needs. To assess their importance on nursing home patients a working group drawn from scientific workers and 40 nursing homes is carrying out five projects: (i) collection of 65 case histories; (ii) assessing the degree of patients' independence in a present situation, introducing changes in opportunities, organization, etc., and assessing the degree of independence after these changes; (iii) patients' abilities and characteristics are studied in relation to their independence and caring for others; (iv) investigation into the rules and daily routine of the nursing home and their effect on patients' active behaviour; and (v) a meals project, where patients prepare light meals for themselves and for less able patients. The last project is the most advanced and so far received with enthusiasm by patients and staff. The entire experiment is still in progress.

1591. LINDENMUTH, Jane E., BREU, Christine S. and MALOOLEY, Jean A. **Sensory overload.** *American Journal of Nursing*, New York, 1980, Aug., vol. 80, no. 8, pp. 1456-1458.

During a particularly busy time on the coronary care unit (CCU) at the University of California Los Angeles Hospital and Clinics, the nursing staff became concerned about the effect of high levels of noise and activity on the patients. The staff nurses developed a project to study the problems of sensory overload in the CCU. In order to identify the environmental stimuli that patients are exposed to, 17 nurses spent one and a half hours in a open ward bed under conditions of intensive care during the busiest time of the day (1000 to 1130). Afterwards they completed a questionnaire. Their reactions included: (i) they felt lonely, neglected and confined; (ii) the most bothersome and persistent noises were telephones ringing, monitor alarms, toilets flushing, handwashing at a nearby sink, conversations and noises from infusor pumps,

respirators and suction pumps; (iii) most felt time slowed down; (iv) discomfort was experienced from equipment; and (v) there was surprise that pressure points developed in such a short time. Based on these responses, the nursing staff developed interventions to try to alleviate the sensory overload for patients, which they organized into a patient care plan (reproduced).

VOLUNTARY SERVICE, VOLUNTARY WORKERS

See Abstract No. 1595

HOSPITAL SOCIAL WORK

See also Abstract No. 1653

1592. NURSE, Gaynor. **Counselling and the nurse: an introduction.** 2nd edition. Aylesbury, H.M. & M., 1980. viii, 116pp. bibliog. ISBN 0 85602 087 7 £3.00

The author discusses: the place of counselling in the process of helping; the practical application of the components fundamental to this skill; and how these can be acquired and developed. The relevance of the basic principles of counselling to the working situation and the practical application of these principles are examined. The application of counselling to nursing, both in hospital and in the community is considered, together with the difficulties and hazards. This second edition discusses some of the current thinking in relation to nursing.

THE GENERAL PRACTITIONER AND HIS PATIENTS

See Abstract Nos. 1619, 1641

TRANSPORT OF PATIENTS

See Abstract No. 1632

HOSPITAL CARE

See also Abstract No. 1534

1593. THOMPSON, Richard E. **PSRO model combines internal, external monitoring.** *Hospital Medical Staff*, Chicago, Ill., 1980, Aug., vol. 9, no. 8, pp. 21-26.

This paper presents a patient care review model that combines internal review and external monitoring. A hospital-based programme of imaginative study and correct interpretation of findings is combined with regional monitoring and consultation. The hospital-based programme, depicted in graphic form, consists of four steps: (i) study methods that go far beyond medical audit and utilization review; (ii) interpretation of the information generated by the study group; (iii) effective use of the findings; and

(iv) an operational definition of the components of high-quality health care. Monitoring by the regional organization must be firm and fair. Effective implementation of this model requires attention to three urgent needs: (i) improvement of internal review components; (ii) development of effective and fair regional monitoring and consultation activities by the local professional standards review organization; and (iii) re-affirmation of the validity of the original professional standards review organization concept.

1594. GUSTAFSON, David H. and others. **Measuring the quality of care in nursing homes: a pilot study in Wisconsin.** *Public Health Reports*, Washington, D.C., 1980, July/Aug., vol. 95, no. 4, pp. 336-343.

The authors discuss the types of models used and the difficulties encountered in assessing the quality of care given in United States nursing homes. In the study reported here, the multi-attribute utility model was used to measure the quality of care in nursing homes in Wisconsin. A table shows the 11 major criteria used in the screening model, with examples of the components of each criterion and the weights assigned to them. The model gave the survey staff the option of approving a home, suggesting consultation or collecting more information on it. Five teams of two people, all with nursing home experience, were chosen to pilot test the model in nine nursing homes. The results of the study showed that the screening model correlated well with the general assessments made of the nursing homes. A two-year study, now under way, involves a comparison between the screening system and traditional assessment methods in 165 nursing homes in both urban and rural areas of the state. The authors predict that the larger study will result in an improvement in the quality and suitability of the care given to nursing home residents.

1595. DURMAN, Eugene C. and others. **Volunteers in social services: consumer assessment of nursing homes.** Washington, D.C., Urban Institute, 1979. xi, 183pp. (URI 27100) ISBN 87766 261 4 $7.00

The Nursing Home Information Project was organized by the Urban Institute to test whether local groups of volunteers, using professionally-developed materials, could conduct effective evaluations of nursing homes. The objectives of the study were: (i) to develop instruments and procedures which could be used by groups to gather and publish data not otherwise available about local nursing homes; (ii) to develop technical materials so that local projects could be completed without the aid of the Urban Institute or similar organizations; and (iii) to assess the impact of the locally-produced information on consumers, long-term care professionals and nursing home administrators. After initial field testing of the questionnaires and checklists, the project concentrated on: (i) monitoring 22 selected sites to test methods and procedures; (ii) modifying instruments and procedures as a result of the sites' implementations; and (iii) assessing the impact of the locally-published materials. The study showed that: (i) most of the groups of volunteers had successfully completed the project; (ii) the vast majority of all groups surveyed indicated that the local nursing home guides were valuable; (iii) the average time taken to complete the projects was 13 months; (iv) most nursing homes participated in the projects, and (v) the strength and commitment of the project co-ordinator and the nature of the sponsors' prior involvement in nursing homes appeared to be the most important factors for success.

TERMINAL CARE

1596. CASTLES, Mary Reardon and MURRAY, Ruth Beckmann. **Dying in an institution: nurse/patient perspectives.** New York, Appleton-Century-Crofts, 1979. xi, 356pp. bibliogs. ISBN 0 8385 1846 X £8.15

This book is intended for registered nurses, licensed practical nurses and nursing attendants who care for dying patients, and is based on interviews with 126 terminal patients and nurses in the United States. The two groups were questioned on their perception of: (i) their own role; (ii) the role of the other group; (iii) the treatment given. A separate chapter gives practical guidance on strategies of care for dying patients, drawn from the views expressed in the survey interviews but also gathered from a review of existing research. Research design and data analysis, documents of ethical statements, legal concerns, the hospice movement, families of the dying and rituals surrounding death are considered in appendices.

1597. VERE, D. W. **The hospital as a place of pain.** *Journal of Medical Ethics*, London, 1980, Sept., vol. 6, no. 3, pp. 117-119.

Whereas the pains and discomforts of disease and dying are well relieved in hospices, they are not in hospitals, at least in sufficient numbers of cases to evoke great disquiet. The reasons for this include: (i) attitudes of staff, both senior and junior, and problems of communication; (ii) factors which arise from the nature of general hospital work; (iii) the nature of the facilities in general hospital wards; and (iv) the reluctance of relatives to allow patients with terminal pain to die at home. The author deprecates the tendency in hospitals to separate 'curing' and 'caring' and suggests that sometimes the best help involves 'doing' less, not more.

1598. THOMPSON, Ian, editor. **Dilemmas of dying: a study in the ethics of terminal care.** Edinburgh, Edinburgh University Press, 1979. xx, 227pp. bibliog. (Edinburgh Medical Group: Moral Issues in Health Care 1) ISBN 0 85224 378 2 £4.00

This study was prepared by the Edinburgh Medical Group Research Project on Professional Attitudes and Values in the Care of the Dying and Bereaved; doctors, nurses, social workers and clergymen were represented on the working group. The first part examines present practice and identifies six areas of moral conflict and dilemma: (i) the basis and justification for professional intervention in terminal care; (ii) the scope and limits of patients' rights in terminal care; (iii) the question of the right to die; (iv) the conflicts experienced by the professional between conscience and professional duty; (v) conflicts of values in inter-professional decision-making; and (vi) the medicalization of bereavement. In the second part of the study a separate chapter is devoted to each of these problems, taking the form of case studies and group discussions. Recommendations relating to professional training and involvement in the care of the dying and the bereaved are set out in an appendix. A large bibliography is included.

1599. BROOKS, Teresa A. **Legal and regulatory issues in hospice care.** *Hospital Medical Staff*, Chicago, Ill., 1980, June, vol. 9, no. 6, pp. 15-21.

The philosophy of hospice care is to improve the quality of the patient's life by alleviating pain, controlling symptoms and caring for the emotional, physical and social

needs of the dying patient. This concept presents new medico-legal problems. Those discussed in this paper relate to: the definition of informed consent; federal and state regulation; and reimbursement.

1600. WELLS, Kay. **Social care for the terminally ill at home and the bereaved: report to Kent County Council Social Services Committee.** Maidstone, Kent Voluntary Service Council, 1980. [i], 67pp. bibliog. £1.00

This report was commissioned by Kent Social Services Committee with two objects: (i) to investigate what is being done elsewhere in the country; and (ii) to make recommendations for Kent. The survey of existing services covers the National Health Service, social services, hospices, the churches and voluntary organizations and informal help; selected schemes are described in greater detail in an appendix. A separate section is concerned with bereavement. The report concludes that the most appropriate way of providing social care to the gravely ill at home is through small-scale local initiatives, and makes recommendations about the means of achieving this in Kent.

1601. KODNER, Dennis L. and FELDMAN, Eli S. **Hospice as part of the care continuum in a comprehensive geriatric center.** *Journal of Long-Term Care Administration*, Washington, D.C., 1980, vol. 8, no. 2, pp. 43-49.

Metropolitan Jewish Geriatric Center, Brooklyn, N.Y., is a 915-bed long-stay facility offering a broad array of institutional and community services 'under one roof'. Its most recent effort to broaden the care continuum is the Brooklyn Hospice. A study of the feasibility of establishing a hospice began in September 1978 and it will be phased in over the next few months. The hospice will provide a co-ordinated programme of in-home, out-patient and institutional care, including after-care, patient transport and consultation and education services. In-patient care will be provided in a special 10-bed continuing care unit located in the skilled nursing pavilion. The unit will have a warm, familiar, 'home-like' atmosphere with flexible visiting hours, facilities for on-demand meal preparation and comfortable accommodation for overnight visitors.

DISCHARGE OF PATIENTS

See Abstract Nos. 1648, 1649

HOME CARE, AFTER-CARE

See Abstract Nos. 1600, 1627

SPECIAL DEPARTMENTS

OPERATING SUITES

See also Abstract No. 1535

1602. MICHAU, Elsie. **Functions of the operating room personnel.** *NATNews*, Matlock, 1980, Sept., vol. 17, no. 9, pp. 24-25, 27.

The operating theatre supervisor has three broad areas of responsibility: organization

and management of the operating services; the professional function of patient care; and the educational function of teaching nursing and domestic staff assigned to her department. The operating theatre sister has a very important role and requires special personal and professional qualities. Her functions are: patient care; education; administration; leadership; communication; and co-ordination. The tutor in the operating area is actively involved in training staff and must keep abreast of current trends. The post-basic operating theatre student must be able to function independently as well as being a member of the operating team. The primary function of the recovery room nurse is the maintenance and observation of the vital functions of the patient with or without the aid of complicated equipment. The student nurse is an essential part of the team because she is the main link between the sterile and non-sterile areas, but has many tasks in the theatre and recovery room.

ANAESTHESIA

1603. FINEBERG, Harvey V. and others. **The case for abandonment of explosive anaesthetic agents.** *New England Journal of Medicine*, Boston, Mass., 1980, Sept. 11, vol. 303, no. 11, pp. 613-617.

The use of inflammable anaesthetics in the United States has been debated widely for several years. The potential benefits from the continued use of explosive anaesthetic agents include: their value in teaching; professional freedom; familiarity with inflammable agents; pharmacological advantages in selected patients; and the desire to retain an option to deal with possible problems in the future. The principle grounds for a ban on inflammable agents are: lack of documented and generally accepted pharmacological advantage of inflammable over non-inflammable agents; decreasing physician familiarity with their use; risk of explosion; and cost. While the use of inflammable anaesthetics has declined markedly, it is estimated that their use adds approximately $9.4 million to the annual cost of surgical care. As their use declines further, the cost per patient increases because most of the costs are fixed. A ban on inflammable anaesthetics is advocated. Without definitive action on the part of policy makers, the use of these agents is likely to continue at a very low, and hence a relatively expensive, rate.

1604. EATON, Jennifer M. **Survey of part-time senior registrar anaesthetists.** *British Medical Journal*, London, 1980, Sept. 13, vol. 281, pp. 758-760.

In June 1979 a questionnaire was sent to 35 female part-time senior registrar anaesthetists. They were asked for an outline of their experience, their reasons for opting for part-time work, details of their present job and their future plans. Reasons for working part-time were: (i) caring for children (25 times); (ii) husband's commitments (six times); (iii) health (twice); and (iv) distance from work (three times). The majority worked from five to seven sessions per week, all provided emergency cover and all had opportunities to gain both general and specialist experience. Twenty respondents thought the training they were receiving was satisfactory. Four intended to acquire further qualifications and 25 wanted to apply for a consultant post, preferably part-time. Limitations of geographical location and the presence of young children at home are both problems for married women approaching qualification for consultant posts.

Possible solutions would be: (i) two part-timers sharing one full-time consultant post; or (ii) a greater willingness in the health service to accept candidates for a limited number of sessions, with the prospect of increased sessions at a later date.

1605. VESSEY, M. P. and NUNN, J. F. **Occupational hazards of anaesthesia.** *British Medical Journal*, London, 1980, Sept. 13, vol. 281, pp. 696-698.

The authors review 12 selected investigations into the possibility that long term exposure to anaesthetic gases present a number of health hazards to man. Two American studies considered the pattern of mortality in anaesthetists and suggested that they are at an increased risk of death by suicide. A British study of 1250 anaesthetists found no excess in mortality but a slightly higher proportion of deaths from pancreatic cancer than that found among other doctors. The remaining nine studies were concerned with a wide range of possible hazards, the most attention being paid to the occurrence of spontaneous abortion and the birth of malformed offspring among women working in anaesthesia. The studies revealed an increase of about 40 per cent in the risk of miscarriage, but the evidence relating to other suspected hazards, including cancer and malformation of offspring was unconvincing. The studies show that: (i) there is an increased risk of abortion among theatre staff; and (ii) occasional exposure to high concentrations of anaesthetic gas may interfere with B12 metabolism. Although the consensus of evidence concerning other hazards is inconclusive, all reasonable steps should be taken to reduce contamination in the operating theatre by the use of scavenging systems.

1606. BROWN, Beryl and ROWLAND, Sally. **The role of the nurse in the anaesthetic room.** *NATNews*, Matlock, 1980, Sept., vol. 17, no. 9, pp. 37-43.

A study of the staffing of anaesthetic rooms and recovery areas and a possible role for nurse anaesthetists involved: (i) a questionnaire to 80 nurses and operating department assistants, 56 per cent of whom replied; (ii) a questionnaire to 30 consultants, registrars and senior house officers, 70 per cent of whom responded; (iii) informal talks with medical and nursing staff; and (iv) a literature survey. The questionnaires are reproduced. The results confirm to some degree the hypotheses: (i) that an anaesthetic room nurse and an operating department assistant are desirable in the anaesthetic area, the former in greater numbers to provide total patient care, the latter to provide the mechanical expertise; and (ii) that the division of the operating suite into dinstinctly separate areas of surgery, anaesthetics and recovery (or with the two latter combined) is not desirable nor likely to happen in the near future. The nursing process should continue throughout the patient's stay whether he is undergoing anaesthesia and surgery or on the ward. An anaesthetic-trained nurse is an essential, not a luxury, if used to her full capacity.

MORTUARIES AND POST-MORTEM ROOMS

1607. CHRISTIAN, M. Sheila, GOSNOLD, J. K. and KERSLEY, P. N. **Confirmation of death.** *British Medical Journal*, London, 1980, Sept. 13, vol. 281, pp. 717-719.

A working party was set up by the Casualty Surgeons Association in 1978 to study the problems surrounding confirmation of death. Current practice was investigated by means of a questionnaire sent to a random sample of accident and emergency depart-

ments in 40 district general hospitals. Of the 38 replying, 24 said that bodies were examined in the ambulance, four in the department, and 10 in both. The respondents' answers showed that they considered present procedures to be unsatisfactory. Organizations consulted, among them the British Medical Association's Forensic Medicine Subcommittee and the Association of Coroners, were unanimous in saying that confirmation of death should not be carried out in the ambulance. A change of practice would, however, create practical problems for many accident and emergency departments. The working party recommends, therefore, that all bodies should be properly examined by a doctor in the accident and emergency department and that the Department of Health and Social Security should make funds available for any necessary changes in buildings and staffing.

PHARMACY

1608. KAY, Bruce G. and others. **How to get the computer into the pharmacy.** *Hospitals*, Chicago, Ill., 1980, July 16, vol. 54, no. 14, pp. 113-114, 116-117.

In order to persuade the hospital management that a computer in the laboratory would be cost effective, pharmacy staff at Kingsbrook Medical Center, Brooklyn, asked the financial director to authorize a feasibility study. The effect of a computer system on departments related to pharmacy were included for the scheme to gain approval. The starting point of the study was a compendium of user needs; to this was added the known and anticipated legislation and accreditation requirements. An expert in data processing identified system needs. After costs had been estimated and an implementation programme planned, a user-oriented computer system was installed in the pharmacy six months after approval had been obtained. The system deals with ordering of drugs, patient profiles and the preparation of doses. Both objectives of improving patient care and reducing costs have been achieved.

1609. PICKUP, J. F. and MORRIS, M. J. **Applications of small computers in hospital pharmacy.** *Pharmaceutical Journal*, London, 1980, Sept. 13, vol. 225, no. 6090, pp. 271-274.

This paper describes the experimental development of two novel pharmacy applications for small computers at the Royal Cornwall Hospital, Treliske, Truro, using the PDP-11 based MUMPS (Massachusetts General Hospital Utility Multi-Programming System) system maintained at Manor Hospital, Walsall. In the first, a programme was written for determining the level of ward drug stocks reflecting the ward's demand for drugs and the ease with which the pharmacy was able to respond to the demand. The second application involved the automation of some of the pharmacy's quality control functions. The experiments showed that a computer can be used to control effectively the value of ward drug stocks and to make a worthwhile contribution to the work load in the quality control section. The implications of these findings are discussed.

1610. AMERICAN SOCIETY OF HOSPITAL PHARMACISTS. **ASHP guidelines on hospital drug distribution and control.** *American Journal of Hospital Pharmacy*, Washington, D.C., 1980, Aug., vol. 37, no. 8, pp. 1097-1103.

These guidelines have been prepared by the Society to assist pharmacists in preparing

drug control procedures for all medicine-related activities. They are based on the premise that the pharmacy is responsible for the procurement, distribution and control of *all* drugs used within the hospital. The guidelines cover: pharmacy policies, procedures and communications; standards, laws and regulations; all aspects of the medication system; and special considerations contributing to drug control.

1611. COARSE, James F. and PIERPAOLI, Paul. **An exchange cart supply-distribution system employed on an institution-wide basis.** *Hospital Pharmacy*, Hagerstown, Md., 1980, Aug., vol. 15, no. 8, pp. 399-406.

This paper describes the pharmacy supply distribution system developed for in-patient units, ambulatory care areas and clinical support service areas at the new University of Connecticut Health Center, Farmington. Before services were instituted at the new centre they were housed at the J. J. McCook Hospital, Hartford. The method employed is a modified exchange trolley system in which duplicate sets of supplies are exchanged at regular and predetermined intervals. It uses unit-of-use packaging whenever feasible and is an extension of the centralized unit dose drug distribution system. Patient unit pharmacists have remained decentralized, but have been relieved of many logistical support responsibilities. Exchange trolleys are used for floor stock and fluid distribution, and exchange cassettes for clinical support service areas and ambulatory medical and dental services. To date, total direct costs of the exchange system are approximately 44 per cent less per adjusted patient day than at the old facility, though all factors at the two facilities are not strictly comparable. Photographs of the trolley and cassettes are included.

1612. EASTAUGH, Steven R. **Limitations on quality assurance effectiveness: improving psychiatric in-patient drug prescribing habits of physicians.** *Journal of Medical Systems*, New York, 1980, vol. 4, no. 1, pp. 27-43.

The ultimate purpose of any quality assurance programme is to improve the effectiveness and efficiency of health care delivery. It has been suggested that the cost of quality assurance and continuing education activities will often be higher than the benefits to patients or society. This study reviews the differential effectiveness of a modest 10 page educational handout on the antipsychotic drug-prescribing habits of psychiatrists and other physicians at 121 Veterans Administration psychiatric units. Counterbalancing the potential inflationary impact of quality assurance activities requires a targeting of resources to those facilities with the highest chance of benefiting from the programmes. The study results indicate that in relation to psychiatric drug use, such activities should be targeted to those services that have: (i) no affiliations with medical schools; (ii) a high ratio of foreign medical graduates; or (iii) a low psychologist staffing ratio per patient.

1613. PARRULLI, Alberto. La distribuzione in dose unitaria dei farmaci negli ospedali: nuove prospettive di riorganizzazione dei servizi di assistenza diretta. **[The distribution of medicines in unit doses in the hospital: new prospects for reorganization of the direct assistance departments.]** *Tecnica e Metodologia Economale*, Firenze, 1980, May/June, vol. 19, no. 3, pp. 175, 177.

The author discusses the advantages of the distribution of medicines in unit doses;

these include an increased safety margin for patient and doctor, a reduction in drug costs, better use of the pharmacist's professional skills and more efficient use of the hospital's drug handbook. The traditional medicine trolley, with its chaotic contents, constantly available to all and sundry, can now disappear from the ward. The difficulties encountered when this system was introduced in the Tuscan Orthopaedic Institute in Florence were mainly psychological.

LABORATORIES

See Abstract Nos. 1508, 1575

BLOOD TRANSFUSION DEPARTMENT

1614. KENDALL, Kenneth E. **Multiple objective planning for regional blood centers.** *Long Range Planning*, Oxford, 1980, Aug., vol. 13, pp. 98-104.

Improperly managed regional blood centres are common in the United States; a recent study showed that the national average for blood outdating was 25 per cent of the blood collected, but some progressive centres have been outdating only five to six per cent. This may be traced to two problems: (i) administrators do not have a method for facilitating the compromises that must be made in the multiple-objective planning problem; and (ii) administrators are not aware of the analytic relationship between their decision variables and their objectives. This paper identifies this relationship and recommends a useful model for solving the multiple-objective planning problem. The model is based on a combination of two methods: (i) sequential elimination by conjunctive constraints; and (ii) a trade-off approach. The development of the model and its application to a large regional blood collection and distribution system are described. This shows that the model achieves its objectives and can be used by regional blood centre managers.

DIAGNOSTIC X-RAY DEPARTMENT

See also Abstract No. 1634

1615. BURKHART, Roger L. **Quality assurance programs for diagnostic radiology facilities: radiation recommendations.** Rockville, Md., Bureau of Radiological Health, 1980. viii, 39pp. (HEW Publication (FDA)80-8110)

Effective quality assurance programmes can ensure that the equipment components of a facility's X-ray system will consistently produce diagnostic quality images with minimum exposure. This publication argues the need for and benefits of quality assurance, and lists, with comments, the Bureau of Radiological Health's recommendations for quality assurance programmes in diagnostic radiological facilities. The recommendations are concerned with: (i) responsibility; (ii) purchase specifications; (iii) monitoring and maintenance; (iv) standards for image quality; (v) evaluation; (vi) records; (vii) information to be contained in a quality assurance manual; (viii)

training; (ix) the need for and duties of a supervisory committee; and (x) a review programme. The results achieved in seven individual quality assurance programmes are described in an appendix.

REHABILITATION

1616. MULLNER, Ross and others. **In-patient medical rehabilitation: 1979 survey of hospitals and units.** *Archives of Physical Medicine and Rehabilitation*, Chicago, Ill., 1980, Aug., vol. 61, no. 8, pp. 341-345.

In April 1979 the Hospital Data Center of the American Hospital Association sent an eight-page questionnaire to 516 hospitals in four categories: (i) independent rehabilitation hospitals; (ii) self-contained rehabilitation hospitals within larger medical centres; (iii) defined rehabilitation units of institutions; and (iv) institutions with no formalized units; 416 completed the questionnaire. The survey yielded information concerning: (i) use and predicted future trends in use; (ii) referral sources of admission; (iii) the areas to which patients are discharged (their homes, nursing homes, etc.); (iv) the classes of full-time equivalent staff and their relative proportions, and those types of staff that hospitals would most like to hire if it were possible to do so; (v) the sources of payment for in-patient claims, and problems with reimbursement; and (vi) other findings, including the use of beds designated as rehabilitation beds for other types of patients and the number of full-time administrators and medical directors.

DEPARTMENTS FOR SPECIAL THERAPY

1617. LINN, Bernard S. **Continuing medical education: impact on emergency room burn care.** *Journal of the American Medical Association*, Chicago, Ill., 1980, Aug. 8, vol. 244, no. 6, pp. 565-570.

A survey in Florida in 1974 revealed a lack of training in burn care, as a result of which the management of burns in emergency rooms was not in keeping with current knowledge and practice. A training programme was developed to improve emergency room care and thereby outcomes of burn patients treated there. This paper describes the programme briefly and evaluates the impact of its implementation in 11 experimental hospitals compared with nine control hospitals. The process of care provided by 298 physicians for 2,492 treated and released patients and 172 admitted patients was significantly better in the hospitals where training had been given. Outcomes of care, such as mortality, morbidity, compliance with medical regimens and satisfaction with care were significantly correlated with training. The study demonstrates that the practice of physicians can be altered favourably by continuing medical education. There is, however, still room for much improvement in emergency medical services.

INTENSIVE CARE UNITS

See Abstract No. 1523

SPECIALIZED HOSPITALS AND UNITS

OUT-PATIENT

See also Abstract Nos. 1637, 1650

1618. CORNELL, Richard G. and others. **The Michigan ambulatory medical care survey: results and utility relative to the national survey.** *Public Health Reports*, Washington, D.C., 1980, July/Aug., vol. 95, no. 4, pp. 369-375.

The Michigan ambulatory medical care survey was carried out from May 1973 to March 1975 to supplement a national survey on the same topic and to obtain more information about ambulatory care provided by non-hospital doctors in Michigan. The results of the Michigan survey were comparable with those of the national survey with respect to race and sex of the patients, diagnoses and number of visits. Fifty-five per cent of Michigan visits were to general physicians as against 40 per cent for the nation. Fewer Michigan visits were to specialists and visits to physicians led to injections and immunizations relatively more frequently than in the national survey. The results of the Michigan survey have been used in designing out-patient services at the Health Care Institute in Detroit, which emphasizes community-based care. Small differences in estimates of need between national and state surveys are not of great practical importance for state planning. However, a state survey may reveal areas where additional investigations could be used to predict needs more accurately. One such area is the provision of X-ray facilities.

1619. DOWIE, Robin. **The referral process and general medicine out-patient system: first report; a statistical analysis.** Canterbury, University of Kent, Health Services Research Unit, 1980. xi, 136pp. bibliog. (H.S.R.U. Report No. 41)

The aims of this study, carried out at a 400-bed district general hospital in south-east England, were: (i) to examine the referral process, in particular the decision of the general practitioner to refer and his explanation of the decision in his referral letter; and (ii) to investigate the relationship between hospital doctors and general practitioners in the out-patient sector as seen in the reliance of hospital clinicians on the local family doctors for the 'workups' done prior to referring new patients and in the factors influencing the consultant's (or his junior doctor's) decisions on treatment or discharge. Two patterns of clinical practice were found in the general practitioners; one group, who practised in health care centres for preference, were relatively high users of the investigatory services and their referral letters more often contained diagnostic formulations similar to those used by hospital doctors, while the other group, practising in conventional premises, used the investigatory services less, averaged fewer referrals and were less likely to commit themselves to a diagnosis. In the out-patient study, a difference was evident between junior hospital doctors and consultants: the former used the pathology services more often, and their overall discharge rate was almost half that of the consultants. Other subjects covered include the influence of the referral letter on out-patient treatment, the co-ordination of diagnostic testing by consultants and general practitioners and the level of demand for radiographs.

CASUALTY AND ACCIDENT

See also Abstract Nos. 1525, 1579, 1607

1620. HOLT, S. and others. **Alcohol and the emergency service patient.** *British Medical Journal*, London, 1980, Sept. 6, vol. 281, pp. 638-640.

Blood alcohol concentrations were measured by breath-alcohol analysis in 702 patients attending the accident and emergency department of the Royal Infirmary, Edinburgh, on 17 different evenings between 2 March and 18 November 1979. Forty per cent of patients had consumed alcohol before attending and 32 per cent had a blood alcohol concentration exceeding 17.4 mmol/l (80 mg/100 ml). Clinical assessment of intoxication resulted in a false-negative diagnosis in 10 per cent of inebriated patients, indicating that an objective measurement of the blood alcohol concentration by a test, such as breath-alcohol analysis, may be of additional value. The findings confirm that a high proportion of emergency department patients are affected by alcohol and suggest that alcoholism treatment facilities need to be integrated with accident and emergency services.

1621. SMITH, Elaine R. **VGH redevelopment begins with critical care.** *Dimensions in Health Service*, Ottawa, Ont., 1980, Aug., vol. 57, no. 8, pp. 14-15.

The new emergency and coronary care facilities at Vancouver General Hospital will open early in 1981 as part of the first phase of the hospital's re-development plan. To meet the expected expansion of the hospital's role as a regional centre, the department was planned to accommodate between 60,000 and 90,000 visits per year. The design is based on a basic pattern of patient flow. The ambulance entrance is separate from the walk-in entrance and immediately inside is the triage area. Admission to the trauma unit (eight beds) will precede transfer to the surgical unit. A 27-bed coronary care unit and a 13-bed observation unit have been planned adjacent to the emergency area. Patients can also be referred from triage to a psychiatric assessment and treatment area. Walk-in patients will be directed from triage to urgent or non-urgent waiting areas to await examination. By means of an automated patient information system, registration as an emergency department patient and a request for admission will be handled as one process. The department will contain its own radiology service and a small laboratory. The building has interstitial floors to carry conduits, pipes and ducts.

1622. TALBERT, Shirley and others. **Improving emergency department care of the sexual assault victim.** *Annals of Emergency Medicine*, Irving, Tex., 1980, June, vol. 9, no. 6, pp. 293-297.

Victims of sexual assault face the multiple threats of disease, unwanted pregnancy, psychological trauma and physical injury, which are further complicated by a comprehensive police investigation. During the last five years, the University of Virginia, Charlottesville, has developed an organized approach to the care of rape victims by appointing a specially trained emergency department nurse who assumes responsibility for co-ordinating their care. The nurse is involved with the patient from the time of arrival through to the court proceedings, serving as a liaison between the

patient and the health professionals and police. The approach, which includes guidelines for patient care, discussion of police investigations, written consent forms and physical evidence recovery units, is described.

1623. CSEPANYI, Attila. **The Hungarian model of an emergency admission and care department.** *Annals of Emergency Medicine*, Irving, Tex., 1980, July, vol. 9, no. 7, pp. 364-367.

In Hungary the general practitioner and ambulance service care for emergency patients on the spot, and patients are then taken to the out-patient area of the hospital. In this system it is not possible to separate emergency patients. The remarkable increase of emergency patients in recent years has created a great burden for the departments working in these traditional conditions. In 1976 an independent emergency department was established in the county hospital at Szolnok; it was the first such department in Hungary. It has 20 in-patient beds, two operating theatres, an 'anti-shock' room, some out-patient rooms, radiography room and laboratory. The department has six full-time physicians, other physicians on rota, 25 nurses and six auxiliary staff. A review of the work of the department shows that it works with high efficiency and has significantly reduced the work of other wards, shortened waiting times, enhanced primary treatment and reduced the mortality rate. A plan of the department and a patient flow pattern are included.

DAY HOSPITALS

1624. MARTIN, A. **The virtue of small day hospitals.** *Demonstration Centres in Rehabilitation Newsletter*, Middlesbrough, 1980, July, no. 21, pp. 24-29.

Over the years a great variety of day hospitals have opened; some are large and fulfil a primarily social role, and others provide between 20 to 50 places a day and are intended to be largely therapeutic, with a high proportion of occupational therapists and physiotherapists. Practical and research experience indicates that large day hospitals are frequently custodial rather than therapeutic, costly to run, difficult to staff, and have seemingly insuperable problems of transport. Results of an investigation of all the day hospitals in the South West Thames Regional Health Authority, both psychiatric and geriatric, involved in the care of the elderly revealed lack of a common policy, lack of rehabilitation, and transport problems. Small day hospitals for the elderly were established in Crawley and Horsham in 1972 and 1974 respectively. They were designed on the principle of providing a small, but highly therapeutic, day hospital in the centre of the population area, but avoiding the duplication of specialist resources of hospitals. Each was planned for 12 patients a day. The use and advantages of these small day hospitals are discussed.

1625. ROONEY, Paul and MATTHEWS, Rowan. **Mental health buildings evaluation: Worcester Development Project for mentally ill people. Report W2. Day centres: policy and user reaction.** London, Department of Health and Social Security, 1980. iv, 88pp. £1.85

The Studdert Kennedy day centre in Worcester, the Malvern day centre, the Covercroft day centre, Droitwich and the Edward Parry day centre, Kidderminster form part of the Worcester Development Project for the mentally ill. The first part of this report

describes the buildings, for which location plans, site plans and building plans are included, and gives details of clients and intensity of building use, admission criteria, activities, client and community involvement, staffing and aims of the centres. The second part discusses factors relating to the current low take up of places and the role of the centres; differences between the centres are noted in: (i) admission criteria; (ii) relations with referring agencies; (iii) client involvement in running the centres; (iv) the amount, and the degree of programming, of activities; (v) involvement with other groups in the community; (vi) duration of attendance; (vii) size and atmosphere; (viii) staff accommodation; and (ix) accessibility and transport arrangements. The third part of the report is concerned with the design of day centre buildings, the day centres as part of the psychiatric service and the relationships between the day centres and day hospitals in the area.

CHILDREN

See also Abstract Nos. 1509, 1572

1626. Leerlingen Berg en Boschschool: eerst scholier, dan pas patiënt. **[Pupils at the Berg and Bosch School, Bilthoven, are considered primarily as students, not as patients.]** *Ziekenhuis*, Utrecht, 1980, Aug. 6, vol. 10, no. 15, pp. 428-429.

The school, attached to the medical centre 'Berg en Bosch', teaches 115 chronically ill children between four and 18 years old. Thirty-five per cent are in-patients; the others are day pupils living at home and daily collected by taxi. Classes range from 12 for younger to seven for older children. The emphasis is on teaching rather than medical treatment, which is carried out outside school hours wherever possible. Attempts are made to create an atmosphere of warmth and security, to help children live with their disabilities and prepare them for life in the outside world. A social worker to maintain contact with parents is attached to the school. On entering the school a child's abilities are tested. Special talents are encouraged and extra coaching given where required.

1627. SIEGEL, Earl and others. **Hospital and home support during infancy: impact on maternal attachment, child abuse and neglect, and health care utilization.** *Pediatrics*, Evanston, Ill., 1980, Aug., vol. 66, no. 2, pp. 183-190.

A study of 321 low income mothers was undertaken to determine the effect of early postpartum contact and of home visits from child care workers on: (i) maternal attachment; (ii) reports of child abuse and neglect; and (iii) the use of child health services. The mothers were randomly assigned to intervention or control groups immediately after delivery. Observations of maternal attachment were made at four months and 12 months. Hospital, health and welfare agency records were examined to discover cases of abuse or neglect and the use made of child health services. After a control had been set up to allow for variables in the maternal background, it was found that early and extended mother and baby contact had only a small influence on the amount of attachment. There were no effects of home visits on cases of child abuse or on use of services. Background variables played a greater part than intervention in determining maternal behaviour. Other measures are needed to overcome problems of poverty and stress which have a detrimental effect on the relationship between mother and baby.

GERIATRICS AND LONG-STAY

See also Abstract Nos. 1590, 1601, 1624, 1651

1628. LEESMAN, Karen S. **Addressing the needs of the 'frail elderly': a model and guideline for strategic planning.** *Hospital Forum*, San Francisco, Calif., 1980, July/Aug., vol. 23, no. 5, pp. 23, 25-26.

The Adult Day Center at Mount Zion Hospital, San Francisco, is open five days a week and admits 35 elderly people a day. Participants must have a medical disability and a team of staff assess each one and devise a treatment plan. Services offered include health maintenance, various therapies, social services, nutrition education, lectures and outings. A number of other programmes have been developed, including: (i) information, counselling and referral; (ii) health screening; (iii) psychiatric consultation; and (iv) home care. Before a commitment is made by a hospital to become involved in geriatrics, six steps should be taken: (i) assess the needs of the elderly in the community; (ii) assess the hospital's position in meeting these needs; (iii) attempt to plan jointly with existing services for the elderly; (iv) be prepared for financial risk; (v) design flexible combinations of services; and (vi) develop criteria for evaluation of the new programme. Potential advantages to the hospital of running a geriatric service include: (i) increased out-patient activity; (ii) greater use of ancillary services; and (iii) the establishment of valuable links with the community.

1629. CATERINICCHIO, Russell Paul and SMITH, Grace P. **The relationship between nursing activity and age: a reassessment of the nursing cost for routine in-patient care differential.** *Hospital Topics*, Sarasota, Fla., 1980, July/Aug., vol. 58, no. 4, pp. 46-50, 55.

Since the introduction of Medicare for elderly patients in the United States, there has been discussion of the cost of treating the elderly relative to other patients. Early studies indicated that age appeared to be significantly related to intensity of services. The Department of Health, Education and Welfare adopted a 'cost differential' by allowing a two percent plus factor across all cost centres. Studies conducted in New Jersey in 1977 resulted in the following conclusions: (i) in spite of empirical studies conducted independently by the American Hospital Association and Commission for Administrative Services in Hospitals in 1966, there is no direct evidence that nursing actually costs more for the elderly; (ii) the implementation of the 8.5 per cent differential for in-patient routine nursing costs for Medicare recipients represented a political fiat in response to pressures from industry interest groups; (iii) changes in the population of Medicare recipients together with advances in nursing and medical practice appear no longer to support a cost differential of any kind; and (iv) preliminary findings of the 1977 studies suggest that older patients consume less nursing care than younger patients when controlling for such case-mix factors as length of stay and surgical intervention.

1630. TRICK, Keith Lloyd Kinsey and DAISLEY, R. A. **A handbook of psychogeriatric care.** Tunbridge Wells, Pitman Medical, 1980. [vi], 161pp. ISBN 0 272 79518 6 £6.50

This book is designed to provide information about the causes and management of common problems in the confused elderly in a way which allows easy reference, and is

intended mainly for those who have not had formal training in psychiatric or general nursing. It is arranged in alphabetical order of problems and their causes, giving practical measures to deal with them.

1631. NORBERG, Astrid, NORBERG, Bo and BEXELL, Göran. **Ethical problems in feeding patients with advanced dementia.** *British Medical Journal*, London, 1980, Sept. 27, vol. 281, pp. 847-848.

Aged patients with dementia, if not stricken by an acute disease, sooner or later approach a terminal phase that is distinguished by a failure of spoon feeding. This condition induces great anxiety in the staff who care for such patients. These staff may feel conflicting demands: you must keep the patient alive; you must not cause the patient pointless suffering; you must not force the patient to eat; you must not talk about death, suffering, and force; and it is not possible to escape. This may be understood as double-binding—whatever the staff member does, he does the wrong thing. Two serious consequences of double-binding are: distancing of staff from the patients; and staff seeking scapegoats for what they do. It is essential that the pressure of double-bindings in the wards should be reduced.

1632. EPSTEIN, Cynthia F. **Wheelchair management: developing a system for long-term care facilities.** *Journal of Long-Term Care Administration*, Washington, D.C., 1980, vol. 8, no. 2, pp. 1-12.

Approximately 35 per cent of all patients in nursing homes require wheelchairs. Given this level of need and the concomitant cost factors of equipment, maintenance and staff, an effective wheelchair management system should become an administrative concern. Before implementing such a system, a large nursing home in New York City conducted a wheelchair needs survey and study. Each wheelchair and user was surveyed and descriptively coded to develop a minimum wheelchair user code. A narrative log was kept of procedural problems, observed and anticipated, as the survey continued. As a result of this, it was possible to reallocate wheelchairs to patients according to their individual needs. The management system developed as a result of the study is covered by five policy statements: (i) appropriate wheelchair assignment to each patient; (ii) a quality assurance programme; (iii) a wheelchair control programme to maintain an adequate supply of appropriate wheelchairs; (iv) a methodology for collection, storage and updating of all wheelchair data; and (v) preventative measures, including educational programmes and routine maintenance and safety checks.

CANCER

1633. GERMAIN, Carol P. Hanley. **The cancer unit: an ethnography.** Wakefield, Mass., Nursing Resources, 1979. ix, 235pp. bibliog. ISBN 0 913654 55 8

A 23-bed cancer ward in a 550-bed urban community general hospital in the United States was studied as a sub-culture; special attention was paid to nurses' roles, problems, stresses, ways of coping with these problems and stresses and consequences of their adaptive behaviour. Separate chapters are concerned with a description of the hospital (unidentified) and its administration, the cancer ward, doctors and patients and their families. Descriptions of incidents observed by the author and quotations

from interviews conducted with staff and patients take up a large part of the study. Recommendations are made for the care of cancer patients, the education of nurses, directions for change in the health care delivery system and subjects for further research.

1634. GEORGE, W. D. and others. **Hospital work load produced by breast-cancer screening programme run by trained non-medical staff.** *British Medical Journal*, London, 1980, Sept. 6, vol. 281, pp. 653-655.

A screening clinic was established in January 1973; nurses and radiographers were trained to examine breasts and read mammograms. Initially each patient was examined twice, once by medical and once by non-medical staff, but once it became clear that the performances of the medical and non-medical teams were similar the screening clinic was run entirely by non-medical staff, who referred patients in whom abnormalities were detected for surgical opinion. The findings of the non-medical staff were used to estimate the hospital work load generated by such a programme. Among 2,490 women who attended for the first time by invitation the rate of referral for a surgical opinion based on the findings of the non-medical staff was 7.9 per cent and the biopsy rate was 2.5 per cent. In the second and third years referral rates fell to 4.7 per cent and 2.7 per cent respectively and the biopsy rates to 1.1 per cent and 1.4 per cent. Rates of referral and biopsy among 1,203 self-referred women were higher. Extrapolation of these findings to a population of 200,000 in a typical health district showed that the hospital work load would be high in the first year of screening with 44 out-patient referrals per week and 14 biopsies. By the third year, however, only seven referrals and four biopsies a week could be expected. The work load would be reduced by a third if screening were confined to women over the age of 50.

EAR, NOSE AND THROAT

See Abstract No. 1653

CARDIOLOGY

See also Abstract Nos. 1520, 1591

1635. NEWBY, Karen. **Aftercare of cardiac surgery patients.** *Nursing Times*, Basingstoke, 1980, Sept. 18, vol. 76, no. 38, pp. 1658-1660.

Recovery from heart surgery is a slow process which some patients find hard to accept. All the staff in the post-operative open heart surgery ward at the Royal Infirmary, Edinburgh, feel the need for better patient contact and feedback. Until recently, patients were each given advice on discharge, by the sister or a staff nurse, on diet, medication and convalescence. A new group meeting project began in May 1979. At the beginning of each week a letter is given to each of the post-operative patients inviting them and their next-of-kin to an informal discussion about their post-operative rehabilitation. The size and membership of the group change each week. The ideal size had proved to be between eight and 12, including a social worker, the sister and a staff nurse. The subjects discussed are outlined. Although the meetings are experimental, some firm conclusions have already been reached about their benefits: (i) clear instructions can be given on medication; (ii) all patients and their relatives have the

opportunity to visit the intensive care unit (ICU); (iii) feedback from patients can be used to improve nursing care for future patients; and (iv) liaison between ward and ICU staff is maintained as a vital part of continuing individual patient care.

UROLOGY

1636. WATERFALL, Wallace K. **Dialysis and transplant.** *British Medical Journal*, London, 1980, Sept. 13, vol. 281, pp. 726-727.

In 1972 an End-Stage Renal Disease programme (ESRD) was set up in the United States to provide for federal government payment of most of the costs of dialysis and kidney tranplantation. The cost of the scheme is increasing rapidly and patients are now included who, owing to chronic disease, have little hope of being rehabilitated to a useful life; indeed, some are depressed by dialysis and have a high suicide rate. Only one-tenth of the scheme's beneficiaries receive transplants, owing to: (i) the age and ill-health of the patients; (ii) the scarcity of kidney donors; and (iii) the increased number of profit-making dialysis centres resulting from the ESRD programme. In order to reduce costs, the government recently altered its ESRD payment structure to make home dialysis more economically attractive to the patient.

1637. WEINMAN, Edward J. and others. **Continuous ambulatory peritoneal dialysis: initial experience as a home-training and an in-hospital procedure.** *Dialysis and Transplantation*, North Hollywood, Calif., 1980, Aug., vol. 9, no. 8, pp. 749-750.

Continuous ambulatory peritoneal dialysis (CAPD) has been offered as an alternative form of home dialysis at Houston Veterans Association Medical Center for five months; 13 patients have been recruited to the programme to date. Home training was given while the patients were in the hospital's renal ward. Training was supervised by a dialysis nurse who instructed the patients in sterile techniques and procedures for solution and catheter changes. In addition, the dietitian and staff physicians instructed the patients in diet changes during the initial introduction to CAPD. The results demonstrate the feasibility of setting up such a programme. Initial clinical and biochemical data are similar to those previously reported. Further observations in a larger group of patients for longer periods will be required to assess the effects of CAPD (versus intermittent peritoneal dialysis and haemodialysis) on other variables. At the present time, however, CAPD appears to be a reasonable alternative to haemodialysis or intermittent peritoneal dialysis for chosen patients.

SURGERY

See also Abstract No. 1545

1638. DIXON, Eileen. **The legal aspects of surgery.** *NATNews*, Matlock, 1980, Sept., vol. 17, no. 9, pp. 18-20, 22.

The author has previously reported her research on the legal aspects of surgery in Great Britain (see *Hospital Abstracts*, Vol. 19, Abstract 603). In a questionnaire sent to 200 doctors and nurses working in operating theatres, 30 of the questions were devised to test the knowledge of the respondents. The relevant part of the questionnaire is now reproduced, with correct answers and the author's comments.

THORACIC SURGERY

See Abstract No. 1635

MATERNITY

1639. BROOME, Annabel K. **Clinical psychology within obstetrics and gynaecology.** *Bulletin of the British Psychological Society*, Leicester, 1980, Sept., vol. 33, pp. 357-359.

A clinical psychologist describes her work in obstetrics and gynaecology over a one-year period in which five sessions a week were held. The period was begun by sitting in on clinics with consultants, nurses and junior doctors. The areas of work were: (i) patients referred for termination of pregnancy; (ii) attendance at antenatal clinics with a consultant and dealing with a variety of problems; (iii) termination of pregnancy of married women and women who know that they are carrying an abnormal child; (iv) psycho-sexual and relationship counselling; and (v) management of patients who had abnormal babies or stillbirths. Obstetrics and gynaecology seem to form one of those fertile areas of work where a service clinical psychologist can explore some quite low-level but effective pieces of information and skills transfer.

1640. O'CONNOR, Susan and others. **Reduced incidence of parenting inadequacy following rooming-in.** *Pediatrics*, Evanston, Ill., 1980, Aug., vol. 66, no. 2, pp. 176-182.

Infants born into low income families at Nashville General Hospital, Tennessee, over a period of nine months were studied. Pairs of mothers and infants were randomly allocated to rooming-in (143 cases) or to routine, less frequent, postpartum contact (158 cases), in order to determine whether rooming-in affects subsequent adequacy in parenting. At a mean age of 17 months, two rooming-in and 10 control children had experienced inadequate parenting, including relinquishing of responsibility by the parent and failure to grow owing to poor feeding. One rooming-in and eight control children were admitted to hospital for their problems. One rooming-in family and five control families were reported for maltreatment of the child and five control children were in the care of adults other than their parents at the time of the study analysis. These findings suggest that rooming-in may be effective in reducing inadequacy in parenting by bonding the parent and the infant into a reciprocal relationship from the outset.

OPHTHALMOLOGY

See Abstract No. 1654

DENTISTRY

See Abstract No. 1525

PSYCHIATRY

See also Abstract Nos. 1612, 1625, 1630, 1631

1641. BEAN, Philip. **Compulsory admissions to mental hospitals.** Chichester, Wiley, 1980. xii, 278pp. bibliog. ISBN 0 471 27758 4 £15.10

This study is in two parts: (i) an examination of the 1959 Mental Health Act and its origins, with special emphasis on the historical background of a change from legalism to treatment in society's approach to mental illness; and (ii) a field study, carried out between 1975 and 1977, of the act as applied in the case of 200 patients. The main aim of the field study was to observe how psychiatrists, social workers and general practitioners operated the act, and its theoretical framework was based on Edwin Lemert's model of group interaction; the labelling theory of mental illness, also developed by Lemert, is tested against the evidence of the survey and is found not to be supported by it. The field study findings are presented in three parts: (i) a socio-demographic survey of the patients and a consideration of the interaction between patients and psychiatrists; (ii) observation of the social setting under which the admissions took place; and (iii) a view of psychiatrists, social workers and general practitioners as rule enforcers. The study, which includes a bibliography, ends with a review of proposals for reform in mental health legislation.

1642. BAER, R., BREUER, St. and FRIESER, W. Die Struktur der psychiatrischen Versorgung aus der Sicht der Kranken. **[The structure of psychiatric care from the patient's viewpoint.]** *Krankenhausarzt*, Karlsruhe, 1980, Aug., vol. 53, no. 8, pp. 612-614, 619-622.

This analysis of psychiatric patients at Erlangen compares those admitted to the university for nervous diseases with those in the large mental hospital. In the case of the former, 100 patients (50 of each sex) were questioned in the autumn of 1978 as to their reasons for not consulting either a specialist or an advisory centre: tables show their diagnoses, time lag before admission, and place of residence. One hundred of the 129 patients admitted to the mental hospital during January and February 1979 are analysed and tables show: whether admission was voluntary or under legal constraint; diagnoses; source of referral; and duration of treatment. The paper also includes data on the 985 in-patients on one particular day, showing voluntary or compulsory admission, length of stay, and number of readmissions. An important difference between the two groups was that only one of the patients in the nervous diseases hospital was compulsorily admitted while 40 per cent of those in the mental hospital were admitted under legal orders. The answers given by patients show clear signs of 'first and second class psychiatry' at the different hospitals although it must be borne in mind that, even before they had experience of psychiatric hospitals, the patients' attitudes had made it difficult to give them proper care. This aspect needs further investigation.

1643. TALBOTT, John A., editor. **State mental hospitals: problems and potentials.** New York, London, Human Sciences Press, 1980. 219pp. ISBN 0 87705 394 4 £10.95

This book examines the problems and potential solutions for state mental hospitals in the United States. The contributers discuss the administrative and personnel

problems, governmental and financial restraints and shortcomings of current treatment programmes. Some authorities maintain that state mental hospitals can still function as comprehensive mental health services, while others suggest that these facilities should be gradually phased out. Alternatives to these proposals are considered, including the conversion of state hospitals to specialized facilities, residential programmes or community mental health centres. The idea of the creation of state mental hospitals adaptable to individual community needs is discussed. By assuming new functions in the mental health system, state hospitals can continue to play an important role in individual and community mental health.

1644. HAMILTON, John R. **The development of Broadmoor 1863-1980.** *Bulletin of the Royal College of Psychiatrists*, London, 1980, Sept., pp. 130-133.

The background of the opening of Broadmoor Hospital for the criminally insane in 1863 is outlined, together with its history and present position. Originally managed by the Home Office, the hospital became the responsibility of the Department of Health and Social Security in 1960, when it also became possible to admit non-offenders for the first time. Details are given of the hospital's current staff and patients.

1645. LOUCAS, K. **Broadmoor's relationship with NHS psychiatric hospitals.** *Bulletin of the Royal College of Psychiatrists*, London, 1980, Sept., pp. 133-135.

There would seem to be an ever increasing need for patients to receive treatment under conditions of security. At the same time, it is becoming increasingly difficult to effect the proper discharge of patients from Broadmoor Hospital and the other special hospitals on transfer to the appropriate catchment area psychiatric hospital. This paper examines the developments which have led to this problem. As a result, some patients remain in Broadmoor Hospital four to six years after their need for treatment under conditions of security has ended and are well enough for placement in an open ward. A plea is made for extended professional contact to restore mutual trust and confidence between the special hospitals and the psychiatric hospitals.

1646. MORAN, Ann E. **Psychiatric bed needs: quantifying the impact of alternative services.** *Journal of Medical Systems*, New York, 1980, vol. 4, no. 1, pp. 9-26.

Despite efforts to control health care costs by reducing the number of hospital beds and increasing ambulatory services, the focus of health planning efforts has been on the establishment of bed capacity goals, without adequate consideration of the effects of alternative services. There is growing consensus that, even for general medical and surgical services, the bed planning methodologies are inadequate. The philosophical emphasis on the importance of alternative services is also poorly reflected in psychiatric services planning methodologies. This study examines the relationship between use of in-patient services by psychiatric patients and varying configurations of out-patient and alternative sources. It focuses on the 41 Veterans Administration (VA) psychiatric hospitals and on the psychiatric patients discharged from these hospitals during 1977. The study leads to findings that contradict basic assumptions of current health planning policies. The evidence is that VA physicians use alternative services to reduce in-patient

days substantially even when there is an oversupply of beds; if there are no adequate out-patient professional services, services are purchased from the general health sector and in-patient use is significantly lower. The main planning implication drawn from the study is that the key to altering psychiatric hospital use rates is not manipulation of the bed supply but rather manipulation of the array and capacity of alternative services.

1647. TIDMARSH, David. **Trends in length of stay at Broadmoor.** *Bulletin of the Royal College of Psychiatrists*, London, 1980, Sept., pp. 135-136.

Broadmoor Hospital's admission and discharge registers and the results of a hospital census taken in 1960 were used in this study of the length of stay of patients in the hospital on 1 January 1960 (shortly before implementation of the Mental Health Act 1959) and all patients admitted and leaving thereafter. Admissions almost trebled in the five years after the implementation of the Mental Health Act, then remained level at about 150 patients a year, but since 1971 have fallen almost back to the 1960 figure. The proportion of patients leaving within five years rose from about 50 per cent for those admitted in 1960 to about 70 per cent for those admitted in 1968 and has since fallen again. There has been no change in those leaving under 10 years. About eight per cent of patients admitted between 1960 and 1964 are still in the hospital. The resident population has declined from 712 males and 173 females on 31 December 1959 to 599 males and 121 females on 31 December 1979. The proportion of short-stay patients in the resident population increased until 1974, but is now falling again reflecting the increasing difficulty in discharging patients.

1648. NUEHRING, Elane M., THAYER, Joel H. and LADNER, Robert A. **On the factors predicting rehospitalization among two state mental hospital patient populations.** *Administration in Mental Health*, New York, 1980, vol. 7, no. 4, pp. 247-270.

The background and performance characteristics of psychiatric patients discharged from two state hospitals in Florida were examined in an effort to distinguish those who were re-admitted from those still in the community after six months. Re-admissions were best distinguished from those still in the community on the basis of continued use of out-patient after-care, low leisure time activity levels, depression and sensitivity to social stigma. They were also likely to be living alone or with non-relatives in a living situation with which they were uncomfortable.

1649. GOSTIN, Larry and RASSABY, Elaine. **Representing the mentally ill and handicapped: a guide to mental health review tribunals.** Sunbury, Quartermaine House for National Association for Mental Health and Legal Action Group, 1980. xix, 215pp. bibliog. ISBN 0 905898 10 9

This guide to the relevant parts of the Mental Health Act 1959 and the Mental Health Review Tribunal Rules 1960 is both an examination of the law and practice of mental health review tribunals (MHRTs) and a handbook to promote effective representation at tribunals, based on the experience of MIND's Legal Department. After a review of the civil and criminal law on admission to and discharge from

psychiatric hospitals, the conditions for applications to MHRTs and their structure and powers are outlined. Practice and procedure in MHRTs are considered under the headings: pre-hearing procedures; the hearing; references by the Home Secretary and Secretary of State for Social Services; the rules of natural justice; and financial representation. A section on the socio-medical context of MHRT representation examines: (i) the medical rationales for detention and treatment of patients and the psychiatric concepts which form the basis of the responsible medical officer's report; and (ii) social aspects, e.g. the accommodation and social support which could be arranged for the patient if discharged. The study also includes comments on current official reviews of the Mental Health Act and the Mental Health Review Tribunal Rules. A select bibliography and tables of statutes and cases are provided.

1650. WILLIAMS, Stephen J. and RICHARDSON, Mary. **Utilization of ambulatory mental health services.** *Administration in Mental Health*, New York, 1980, vol. 7, no. 4, pp. 304-321.

The use of mental health services is difficult to project for populations enrolled in prepaid group practices and other insurance plans due to limitations on the availability of data and the absence of any analytical frameworks for examining the data that are available. Using secondary data sources from the available literature, this paper: (i) examines the use of ambulatory mental health services from the perspective of a policy maker or planner seeking to anticipate the potential use of such services; (ii) illustrates the processes of applying existing information to this common planning problem; and (iii) provides an overview of the research that has been reported on the use of ambulatory mental health services. Aggregate data indicate that use can range to over 200 visits annually per 1,000 persons for enrolled population groups, although much of the historical data do not suggest such high rates. Variables such as age, sex, and race as well as the structure of the provider system are predictive of use behaviour. A list of 74 references to the literature is included.

1651. MIND. **Positive approaches to mental infirmity in elderly people: MIND's annual conference report, October 1978.** (Chairman: Sir Martin Roth). [London], MIND, 1979. [ii], 116pp. £1.95

The 1978 annual conference of MIND was devoted to a radical appraisal of the position of elderly people and the promotion of new approaches and services, as preparation for a campaign to draw attention to effective ways of meeting the needs of elderly mentally ill and infirm people. Subjects discussed in the paper presented are: a review of the problems and measures needed to counter them; the position of elderly people in society; the promotion of mental health in the elderly; the development of services within the community; elderly mentally handicapped people; assessment and early intervention; the geriatric day unit at St. Thomas' Hospital; the community role of psychiatric units for older people; reality orientation in theory and in practice; the need for a central advisory service for the elderly; research into staff attitudes and activities in psychogeriatric wards; group living in residential homes in Northamptonshire; a boarding-out scheme in Leeds; Age Concern Gateshead's hospital after-care service; self help and the work of Task Force; and courses for staff working in residential homes and hostels for the elderly, caring for the confused elderly.

1652. FELCE, David, MANSELL, Jim and KUSHLICK, Albert. **Evaluation of locally-based hospital units for the mentally handicapped in Wessex: a comparison of the capital and operating costs of Wessex locally-based hospital units and villas on traditional hospital campuses.** Winchester, Health Care Evaluation Research Team, 1980. [ii], 104pp. bibliog. (Research Report No. 146)

The Wessex Regional Health Authority contains 10 locally-based hospital units for mentally handicapped people. This report forms part of a research project to evaluate such units in comparison with the traditional mental handicap hospital; it tests two predictions made when the units were first proposed: (i) that the capital cost per residential place would be lower in the locally-based hospital units than in the traditional mental hospital; and (ii) that the revenue costs per resident per day would be lower in the traditional hospital but that, with equality in the staffing costs, the units would be no more expensive, or even cheaper. The hospitals studied in the cost comparison were Coldeast Hospital (563 places), Tatchbury Mount Hospital (395 places), Princess Marina Hospital, Northampton (506 places) and Gloucester Centre, Peterborough (100 places). The surveys of capital costs and revenue costs are set out separately; each part describes the method used for the survey, presents the results, with extensive use of tables, and discusses the findings. The report contains 38 references to the literature.

1653. BONE, Nigel. **Walls within walls at Rampton.** *Community Care*, Sutton, 1980, Oct. 2, no. 329, pp. 20-21.

Deafness is probably the least understood handicap facing our society. A deaf person in a top security hospital such as Rampton Hospital faces an extra burden. Deaf patients there are not given any special facilities, the numbers involved making this impractical. Although the hospital has its own social work department, social workers for the deaf from Nottinghamshire visit the hospital's deaf patients. A group of deaf patients meets fortnightly, mainly in an attempt to alleviate their isolation. The group attempts to enable patients to relate to each other and to express themselves. Individual sessions are used to attempt to discuss with patients their feelings towards their offences and the treatment offered within the hospital. The social worker is also involved in liaison with both consultant and nursing staff and acts as an interpreter. Because of difficulties in communication, it takes longer for deaf people to progress through the hospital system.

1654. KROPKA, Barbara and WILLIAMS, Chris. **A survey of blind and partially sighted residents in the mental handicap hospitals of Devon.** *Apex*, Kidderminster, 1980, Sept., vol. 8, no. 2, pp. 43-44.

The receipt of a national questionnaire prompted the Royal Western Counties Hospitals (RWCH) Group to survey the visually handicapped minority among its mentally handicapped patients. The results are presented and compared with those from the national survey. The principal findings were: (i) the group has more visually handicapped people than might have been expected from the national survey, most of them in the 30 to 59 and 60 and over age groups; (ii) more visually handicapped RWCH people than expected were in the mildly mentally handicapped range and fewer had IQs below 50; and (iii) less training or provision of an occupation was being made for RWCH blind and partially sighted residents. The availability of these data enabled initial moves to be made towards an improvement in services for this population.

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